Department of Economic Security
Community Services Administration

Homeless Coordination Office

Annual Report

The Current Status of Homelessness in Arizona and efforts to Prevent or Alleviate Homelessness

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TABLE OF CONTENTS

Executive Summary

This eighth annual report on homelessness in Arizona provides information about homelessness, including the causes of homelessness, demographic characteristics of people who are homeless, and issues homeless people face. In addition, the report will highlight the progress made in the past year in assisting homeless people, current funding of programs to assist homeless people and summary descriptions of these programs, and a review of federal, state and local efforts to prevent and alleviate homelessness in Arizona.

There are many reasons people become homeless. The most common factor is poverty, but not everyone in poverty becomes homeless. This report provides information on the many variables that contribute to homelessness and provides information about homeless persons and programs in Arizona. In addition to a high poverty rate as a major factor in homelessness, domestic violence, substance abuse, mental illness, a lack of affordable housing, declines in public assistance, inadequate wages and a lack of affordable health care all play a role in the continuing existence of homelessness as a major social issue in Arizona and the rest of this country.

Homeless single persons constitute the largest single group of homeless persons, but the trend is that the number of homeless persons in families appears to be the fastest growing group. Among the single population, at any point in time, a majority is reported by emergency shelter and transitional housing programs as having problems with substance abuse, serious mental illness, or both. In major urban areas, many have recently been released from the Arizona prison system and a majority of these individuals also have substance abuse histories. Shelters are faced with the challenge of assisting these individuals not only with shelter, but also with the services necessary to help them deal with their behavioral health issues. However, funding from state and some federal sources is extremely limited for this population, due to priority being placed on programs for families.

Homeless families constitute the largest number of persons in shelters and transitional housing, not because they are the largest group, but because there are more beds available for this group. Single female-headed families make up the majority of homeless families. Substance abuse and mental illness is less prevalent among families, although substance abuse is a significant issue. Domestic violence is a major cause of homelessness for women with children and for single women. Thousands of women and children are turned away from domestic violence shelters every year due to a lack of available bed space.

The exact number of homeless people at any point in time is not known due to the difficulty of counting a population that is not easily located or identified, as many of them do not want to be identified as homeless. However, based on estimates provided by community groups from throughout the state, there may be as many as 26,000 homeless people in Arizona at any given time. These estimates include those persons who are in shelters or transitional housing (5,500 in January 1999), or other locations such as on the streets, camped in the forests, living in cars or buildings that are unsuitable for habitation. In spite of an overall positive economic picture in the state, the large number of households earning less than a livable wage and a disproportionate rise in housing costs versus incomes point to increasing numbers of homeless persons.

The number of shelter beds in the state is estimated at almost 2,600 emergency shelter beds and over 4,200 transitional housing beds. There are over 160 emergency shelter and transitional housing programs in the state, with many other organizations providing a variety of other services to assist homeless people. However, survey data indicates that hundreds of homeless families and individuals are turned away from shelter every day due to lack of space.

Funding for homeless assistance programs comes from all levels of government and the private sector. The number of beds and services has grown, but the number of new homeless families and individuals continue to put severe pressure on the existing programs and resources. No major new sources or increases in existing funding sources have been identified or created in the past year except through the Temporary Assistance to Needy Families program which provides emergency assistance to eligible families with children. A Joint Legislative Committee on Homelessness, authorized by the 1999 Legislature began meeting in the last quarter of the year. This committee is charged to:

"Serve as a public forum for the purpose of discussing issues regarding current and potential services and programs to reduce homelessness and to assist the homeless.

Advise the private sector and the executive branch of government of programs and policies pertaining to homelessness.

Review homelessness programs and services to ensure efficient and coordinated use of resources.

Submit periodic reports concerning homelessness issues, including an annual report, to the governor the speaker of the house of representatives and the president of the senate."

Issues identified by advocates and service providers include:

A lack of affordable housing for homeless persons to move into when they have completed available programs.

Over reliance on federal homeless housing funds for homeless seriously mentally ill persons that limits availability of funds for other populations.

A lack of substance abuse treatment funding for homeless substance abusers.

Insufficient shelter and services for runaway and homeless youth.

A lack of housing and specialized programs for homeless veterans.

A lack of shelter beds for victims of domestic violence.

I. Introduction

Pursuant to Laws 1990, Chapter 260 (H.B. 2318) and as required by Section A.R.S. 41-1954 (A), the State Homeless Coordination Office of the Arizona Department of Economic Security (DES) annually submits a report regarding the status of homelessness and efforts to prevent and alleviate homelessness to the Governor, the President of the Senate and the Speaker of the House.

The eighth annual report provides information about homelessness including the causes of homelessness, demographic characteristics of people who are homeless, and issues homeless people face. In addition, the report will highlight the progress made in the past year in assisting homeless people, current funding of programs to assist homeless people and summary descriptions of these programs, and a review of federal, state and local efforts to prevent and alleviate homelessness in Arizona.

Information excerpted directly from outside sources is referenced at the beginning of the excerpted section(s) and printed in Italics. References from outside sources can be obtained directly from the source listed.

II. Homelessness Defined

A. Definitions of Homelessness:

Federal Definition: U.S Code: Title 42, Section 11302

National Coalition for the Homeless (NCH) (February, 1999). *Who Is Homeless? NCH Fact Sheet #3.* [WWW document]. URL http://nch.ari.net/who.html

According to the Stewart B. McKinney Act, 42 U.S.C. § 11301, et seq. (1994), a person is considered homeless who "lacks a fixed, regular, and adequate night-time residence and; and... has a primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations... (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings." 42 U.S.C. § 11302(a) The term "'homeless individual' does not include any individual imprisoned or otherwise detained pursuant to an Act of Congress or a state law." 42 U.S.C. § 11302(c)

This definition is usually interpreted to include only those persons who are literally homeless -- that is, on the streets or in shelters -- and persons who face imminent eviction (within a week) from a private dwelling or institution and who have no subsequent residence or resources to obtain housing. The McKinney definition of homelessness serves large, urban communities, where tens of thousands of people are literally homeless. However, it may prove problematic for those persons who are homeless in areas of the country, such as rural areas, where there are few shelters. People experiencing homelessness in these areas are less likely to live on the street or in a shelter, and more likely to live with relatives in overcrowded or substandard housing (U.S. Department of Agriculture, 1996).

Arizona TANF Definition: A.R.S. 46-241 (5)

"Homeless" means the participant has no permanent place of residence where a lease or mortgage agreement between participant and the owner exists.

B. Who Are Homeless People?

Homelessness can affect anyone. Loss of a job, a health crisis, domestic violence, the loss of family support and a myriad of other events can trigger homelessness. Homelessness effects people of all ages and ethnicity's. Following is a brief description of the major sub-populations of homeless people.

Homelessness Among Elderly Persons

National Coalition for the Homeless (NCH) (June, 1999). *Homelessness Among Elderly Persons: NCH Fact Sheet #15*. [WWW document]. URL http://nch.ari.net/elderly.html

Between 1980 and 1993, the total number of older households in the United States --that is, households headed by someone over the age of 65 -- increased by 31% (Gaberlavage and Sloan, 1997). Among this growing population are older adults who have grown old on the street, those who have recently become homeless, and others at risk of displacement from their homes.

DEFINITIONS AND DIMENSIONS

Definitions of aged status vary from study to study; however, there is a growing consensus that persons aged 50 and over should be included in the "older homeless" category. Homeless persons aged 50-65 frequently fall between the cracks: they are not old enough to receive Medicare, but their physical health, aggravated by poor nutrition and severe living conditions, may resemble that of a 70-year-old.

A 1992 Urban Institute study found that 31% of homeless persons were over the age of 45 (Burt, 1992); other studies have found proportions of homeless persons aged 55 to 60 ranging from 2.5% to 19.4% (Institute of Medicine, 1988). Although the proportion of older persons among the homeless population has declined over the past two decades, their absolute number has grown (Cohen, 1996).

CAUSES

Increased homelessness among elderly persons is largely the result of the declining availability of affordable housing and poverty among certain segments of the aging. Of the 12.5 million persons in households identified by the U.S. Department of Housing and Urban Development as having "worst case housing needs," 1.5 million are elderly people (U.S. Department of Housing and Urban Development, 1998)..[1] Among households with very low incomes, households with an elderly head of household have almost a one-in-three chance of having worst case needs, despite the fact that housing assistance has been heavily directed toward elderly people. Thirty-seven percent of very-low-income elderly people receive housing assistance.

The total number of elderly with very low incomes dropped between 1993 and 1995 by about 300,000 (U.S. Department of Housing and Urban Development, 1998). This drop may reflect a growing portion of the elderly population protected from severe poverty by Social Security and private

pensions. A recent analysis of Census data found that without Social Security, nearly half (47.6%) of Americans age 65 or over would have been poor in 1997 (Center on Budget and Policy Priorities, 1999). In fact, Social Security reduced the poverty rate among elderly people in 1997 by 11.9%, and lifted 11.4 million elderly people out of poverty.

Still, many elderly people are poor and in need of housing assistance. While elderly people have a lower poverty rate than the general population (10.5% compared to 13.3% for all people), they are more likely than the nonelderly to have incomes just over the poverty threshold (U.S. Bureau of the Census, 1998). Seventeen percent of elderly people had family incomes below 125 percent of poverty. Sixty-five percent of older renters, 71% of older single female renters, 71% of older Hispanic renters, and 69% of older African-American renters spend more than 30% of their income on housing (Gaberlavage and Citro, 1997).

With less income for other necessities such as food, medicine, and health care, these populations are particularly vulnerable to homelessness. Overall economic growth will not alleviate the income and housing needs of elderly poor people, as continuing or returning to work, or gaining income through marriage, are often unlikely.

Isolation also contributes to homelessness among older persons; older persons are almost twice as likely than younger homeless persons to have been living alone prior to losing their home (Cohen, 1996).

CONSEQUENCES

Once on the street, elderly homeless persons often find getting around difficult, and, distrusting the crowds at shelters and clinics, they are more likely to sleep on the street. Some studies show that homeless persons who are elderly are prone to victimization and more likely to be ignored by law enforcement. A study from Detroit, for example, found that almost half of older homeless persons had been robbed and one-fourth had been assaulted within the preceding year (Douglass, 1988). Older homeless persons are also more likely to suffer from a variety of health problems, including chronic disease, functional disabilities, and high blood pressure, than are other homeless persons (Cohen, 1996).

PROGRAM AND POLICY ISSUES

Most older homeless persons are entitled to Social Security benefits; however these benefits are often inadequate to cover the cost of housing. In 1998, on a national average, a person receiving Supplemental Security Income (SSI) benefits had to spend 69% of his or her SSI monthly income to rent a one-bedroom apartment at Fair Market Rent; in more than 125 housing market areas, the cost of a one-bedroom apartment at Fair Market Rent was more than a person's total monthly SSI income (Technical Assistance Collaborative & the Consortium for Citizens with Disabilities Housing Task Force, 1999). In most states, even if the SSI grant does cover the rent, only a few dollars remain for other expenses. Moreover, some homeless persons are unaware of their own eligibility for public assistance programs and face difficulties applying for and receiving benefits. Elderly homeless persons in particular often need help navigating the complex application process.

To prevent elderly Americans from becoming homeless, we must provide enough low-income housing, income supports, and health care services to sustain independent living. For those older adults who have already lost their homes, comprehensive outreach health and social services must be

made available, as well as special assistance to access existing public assistance programs. Finally, like all people who are homeless or at risk of becoming homeless, elderly people need an adequate income, affordable housing, and affordable health care in order to stay securely housed.

FOOTNOTES

1."Worst case needs" refers to those renters with incomes below 50% of the area median income who are involuntarily displaced, pay more than half of their income for rent and utilities, or live in substandard housing.

Homelessness Among the Elderly in Arizona

There is a limited amount of information available about older homeless persons in Arizona. Central Arizona Shelter Services of Phoenix reports that it served 36 persons aged 65 and over during the period of July 1, 1998 through June 30 1999. The Phoenix Health Care for the Homeless Coalition's 1996 Survey Data, "A Snapshot of Homeless People in Phoenix" reported that 11.3 percent of 1100 persons interviewed were over the age of 65. There are no known emergency shelters solely devoted to serving elderly homeless persons in Arizona and only one transitional housing program with 45 beds available for elderly persons and/or persons with physical disabilities.

Homeless Families with Children

National Coalition for the Homeless (NCH) (June, 1999). *Homeless Families with Children: NCH Fact Sheet #7.* [WWW document]. URL http://nch.ari.net/families.html

Homelessness is a devastating experience for families. It disrupts virtually every aspect of family life, damaging the physical and emotional health of family members, interfering with children's education and development, and frequently resulting in the separation of family members. The dimensions, causes, and consequences of family homelessness are discussed below. An overview of policy issues and a list of resources for further study are also provided.

DIMENSIONS

One of the fastest growing segments of the homeless population is families with children. Families with children constitute approximately 40% of people who become homeless (Shinn and Weitzman, 1996). A survey of 30 U.S. cities found that in 1998, children accounted for 25% of the homeless population (U.S. Conference of Mayors, 1998). These proportions are likely to be higher in rural areas; research indicates that families, single mothers, and children make up the largest group of people who are homeless in rural areas (Vissing, 1996).

Recent evidence confirms that homelessness among families is increasing. Requests for emergency shelter by families with children in 30 U.S. cities increased by an average of 15% between 1997-1998 (U.S. Conference of Mayors, 1998). The same study found that 32% of requests for shelter by homeless families were denied in 1998 due to lack of resources. Moreover, 88% of the cities surveyed expected an increase in the number of requests for emergency shelter by families with children in 1999.

CAUSES

Poverty and the lack of affordable housing are the principal causes of family homelessness. The number of poor people increased 41% between 1979 and 1990; families and children under 18 accounted for more than half of that increase (U.S. House of Representatives, 1992). Today, 40% of persons living in poverty are children; in fact, the 1997 poverty rate of 19.9% for children is almost twice as high as the poverty rate for any other age group (U.S. Bureau of the Census, 1998).

Stagnating wages and changes in welfare programs account for increasing poverty among families. In the median state, a minimum-wage worker would have to work 87 hours each week to afford a two-bedroom apartment at 30% of his or her income, which is the federal definition of affordable housing (National Low Income Housing Coalition, 1998). Until its repeal in August 1996, the largest cash assistance program for poor families with children was the Aid to Families with Dependent Children (AFDC) program. Between 1970 and 1994, the typical state's AFDC benefits for a family of three fell 47%, after adjusting for inflation (Greenberg and Baumohl, 1996). The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the federal welfare reform law) repealed the AFDC program and replaced it with a block grant program called Temporary Assistance to Needy Families (TANF). Current TANF benefits and Food Stamps combined are below the poverty level in every state; in fact, the median TANF benefit for a family of three is approximately one-third of the poverty level. Thus, contrary to popular opinion, welfare does not provide relief from poverty.

Welfare caseloads have dropped sharply since the passage and implementation of welfare reform legislation. However, declining welfare rolls simply mean that fewer people are receiving benefits -- not that they are employed or doing better financially. Early findings suggest that although more families are moving from welfare to work, many of them are faring poorly due to low wages and inadequate work supports. Only a small fraction of welfare recipients' new jobs pay above-poverty wages; most of the new jobs pay far below the poverty line (Children's Defense Fund and the National Coalition for the Homeless, 1998). Moreover, extreme poverty is growing more common for children, especially those in female-headed and working families. This increase can be traced directly to the declining number of children lifted above one-half of the poverty line by government cash assistance for the poor.

As a result of loss of benefits, low wages, and unstable employment, many families leaving welfare struggle to get medical care, food, and housing. Many lose health insurance, despite continued Medicaid eligibility: a recent study found that 675,000 people lost health insurance in 1997 as a result of the federal welfare reform legislation, including 400,000 children (Families USA, 1999). In addition, housing is rarely affordable for families leaving welfare for low wages, yet subsidized housing is so limited that fewer than one in four TANF families nationwide lives in public housing or receives a housing voucher to help them rent a private unit. For most families leaving the rolls, housing subsidies are not an option. In some communities, former welfare families appear to be experiencing homelessness in increasing numbers (Children's Defense Fund and the National Coalition for the Homeless, 1998).

The shrinking supply of affordable housing is another factor underlying the growth in family homelessness. The gap between the number of affordable housing units and the number of people needing them is currently the largest on record, estimated at 4.4 million units (Daskal, 1998). The affordable housing crisis has had a particularly severe impact on poor families with children.

Families with children represent 40% of households with "worst case housing needs" -- those renters with incomes below 50% of the area median income who are involuntarily displaced, pay more than half of their income for rent and utilities, or live in substandard housing (U.S. Department of Housing and Urban Development, 1998). With less income available for food and other necessities, these families are only an accident, illness, or paycheck away from becoming homeless.

More recently, the strong economy has caused rents to soar, putting housing out of reach for the poorest Americans. Between 1995 and 1997, rents increased faster than income for the 20% of American households with the lowest incomes (U.S. Department of Housing and Urban Development, 1999). As a result, more families are in need of housing assistance. From 1996-1998, the time families spent on waiting lists for HUD housing assistance grew dramatically. For the largest public housing authorities, a family's average time on a waiting list rose from 22 to 33 months from 1996 to 1998 - a 50% increase. The average waiting period for a Section 8 rental assistance voucher rose from 26 months to 28 months between 1996 and 1998. Excessive waiting lists for public housing mean that families must remain in shelters or inadequate housing arrangements longer. Consequently, there is less shelter space available for other homeless families, who must find shelter elsewhere or live on the streets.

Domestic violence also contributes to homelessness among families. When a woman leaves an abusive relationship, she often has nowhere to go. This is particularly true of women with few resources. Lack of affordable housing and long waiting lists for assisted housing mean that many women are forced to choose between abuse and the streets. In a study of 777 homeless parents (the majority of whom were mothers) in ten U.S. cities, 22% said they had left their last place of residence because of domestic violence (Homes for the Homeless, 1998). In addition, 46% of cities surveyed by the U.S. Conference of Mayors identified domestic violence as a primary cause of homelessness (U.S. Conference of Mayors, 1998).

CONSEQUENCES

Homelessness severely impacts the health and well-being of all family members. Compared with housed poor children, homeless children experience worse health; more developmental delays; more anxiety, depression and behavioral problems; and lower educational achievement (Shinn and Weitzman, 1996). A recent study of the health status of homeless children in New York City found that 61% of homeless children had not received their proper immunizations (compared to 23% of all New York City two-year-olds); 38% of homeless children in the City's shelter system have asthma (an asthma rate four times that for all New York City children and the highest prevalence rate of any child population in the United States); and that homeless children suffer from middle ear infections at a rate that is 50% greater than the national average (Redlener and Johnson, 1999). These illnesses have potentially devastating consequences if not treated early.

Deep poverty and housing instability are especially harmful during the earliest years of childhood; alarmingly, it is estimated that almost half of children in shelter are under the age of five (Homes for the Homeless, 1998). School-age homeless children face barriers to enrolling and attending school, including transportation problems, residency requirements, inability to obtain previous school records, and lack of clothing and school supplies.

Parents also suffer the ill effects of homelessness and poverty. One study of homeless and low-income housed families found that both groups experienced higher rates of depressive disorders than the

overall female population, and that one-third of homeless mothers (compared to one-fourth of poor housed mothers) had made at least one suicide attempt (Bassuk et al., 1996). In both groups, over one-third of the sample had a chronic health condition.

Homelessness frequently breaks up families. Families may be separated as a result of shelter policies which deny access to older boys or fathers. Separations may also be caused by placement of children into foster care when their parents become homeless. In addition, parents may leave their children with relatives and friends in order to save them from the ordeal of homelessness or to permit them to continue attending their regular school. The break-up of families is a well-documented phenomenon: in New York City, 60% of residents in shelters for single adults had children who were not with them; in Maryland, only 43% of parents living in shelters had children with them; and in Chicago, 54% of a combined street and shelter homeless sample were parents, but 91% did not have children with them (Shinn and Weitzman, 1996).

POLICY ISSUES

Policies to end homelessness must include jobs that pay livable wages. In order to work, families with children need access to quality child care that they can afford, and adequate transportation. Education and training are also essential elements in preparing parents for better paying jobs to support their families.

But jobs, child care, and transportation are not enough. Without affordable, decent housing, people cannot keep their jobs and they cannot remain healthy. A recent longitudinal study of poor and homeless families in New York City found that regardless of social disorders, 80% of formerly homeless families who received subsidized housing stayed stably housed, i.e. lived in their own residence for the previous 12 months (Shinn and Weitzman, 1998). In contrast, only 18% of the families who did not receive subsidized housing were stable at the end of the study. As this study and others demonstrate, affordable housing is a key component to resolving family homelessness. Preventing poverty and homelessness also requires access to affordable health care, so that illness and accidents no longer threaten to throw individuals and families into the streets.

Only concerted efforts to meet all of these needs will end the tragedy of homelessness for America's families and children.

Homeless Families with Children in Arizona

In a January 1999 statewide shelter survey, the Arizona State Homeless Coordination Office identified 273 families in emergency shelter and 488 families in transitional housing programs for a total of 761 homeless families in shelter on a given day. These families included 843 adults and 1,523 children. This indicates a high percentage of single parent households, the majority of whom are women. Twenty-five percent of the persons in families indicated a history of domestic violence. An increasing percentage of families identified a loss of welfare benefits as a contributing cause of their homelessness. Based on data from reports submitted to the Arizona Department of Economic Security, Community Services Administration by homeless shelters, the Homeless Coordination office estimates that as many as 13,410 persons in families receive emergency shelter in one year and 12,708 receive transitional housing in one year. In addition, survey data specified that 168 families were turned away from emergency shelter and transitional housing programs in a one-day period in January 1999.

Homeless Youth

National Coalition for the Homeless (NCH) (April, 1999). *Homeless Youth: NCH Fact Sheet #11*. [WWW document]. URL http://nch.ari.net/youth.html

DEFINITIONS AND DIMENSIONS

Homeless youth are individuals under the age of eighteen who lack parental, foster, or institutional care. These young people are sometimes referred to as "unaccompanied" youth.

The homeless youth population is estimated to be approximately 300,000 young people each year (Institute for Health Policy Studies, 1995). According to the Research Triangle Institute, an estimated 2.8 million youth living in U.S. households reported a runaway experience during the prior year (U.S. Department of Health and Human Services(a), 1995). According to the U.S. Conference of Mayors, unaccompanied youth account for 3% of the urban homeless population (U.S. Conference of Mayors, 1998).

CAUSES

Causes of homelessness among youth fall into three inter-related categories: family problems, economic problems, and residential instability.

Many homeless youth leave home after years of physical and sexual abuse, strained relationships, addiction of a family member, and parental neglect. Disruptive family conditions are the principal reason that young people leave home: in one study, more than half of the youth interviewed during shelter stays reported that their parents either told them to leave or knew they were leaving and did not care (U.S. Department of Health and Human Services (a), 1995). In another study, 46% of runaway and homeless youth had been physically abused and 17% had been forced into unwanted sexual activity by a family or household member (U.S. Department of Health and Human Services (c), 1997).

Some youth may become homeless when their families suffer financial crises resulting from lack of affordable housing, limited employment opportunities, insufficient wages, no medical insurance, or inadequate welfare benefits. These youth become homeless with their families, but are later separated from them by shelter, transitional housing, or child welfare policies (Shinn and Weitzman, 1996).

Residential instability also contributes to homelessness among youth. A history of foster care has been found to be correlated with becoming homeless at an earlier age and remaining homeless for a longer period of time (Roman and Wolfe, 1995). Some youth living in residential or institutional placements become homeless upon discharge -- they are too old for foster care but are discharged with no housing or income support (Robertson, 1996). One national study reported that more than one in five youth who arrived at shelters came directly from foster care, and that more than one in four had been in foster care in the previous year (National Association of Social Workers, 1992).

CONSEQUENCES

Homeless youth face many challenges on the streets. Few homeless youth are housed in emergency shelters as a result of lack of shelter beds for youth, shelter admission policies, and a preference for greater autonomy (Robertson, 1996). Because of their age, homeless youth have few legal means by which they can earn enough money to meet basic needs. Many homeless adolescents find that

exchanging sex for food, clothing, and shelter is their only chance of survival on the streets. In turn, homeless youth are at a greater risk of contracting AIDS or HIV-related illnesses. HIV prevalence studies anonymously performed in four cities found a median HIV-positive rate of 2.3% for homeless persons under age 25 (Robertson, 1996). Other studies have found rates ranging from 5.3% in New York to 12.9% in Houston. It has been suggested that the rate of HIV prevalence for homeless youth may be as much as 2 to 10 times higher than the rates reported for other samples of adolescents in the United States (National Network for Youth, 1998).

Homeless adolescents often suffer from severe anxiety and depression, poor health and nutrition, and low self-esteem. In one study, the rates of major depression, conduct disorder, and post-traumatic stress syndrome were found to be 3 times as high among runaway youth as among youth who have not run away (Robertson, 1989).

Furthermore, homeless youth face difficulties attending school because of legal guardianship requirements, residency requirements, proper records, and lack of transportation. As a result, homeless youth face severe challenges in obtaining an education and supporting themselves emotionally and financially.

PROGRAM AND POLICY ISSUES

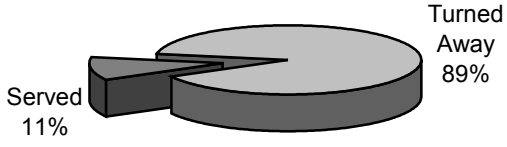
Homeless youth benefit from programs which meet immediate needs first, then help them address other aspects of their lives. Programs which minimize institutional demands and offer a range of services have had success in helping homeless youth regain stability (Robertson, 1996). Educational outreach programs, assistance in locating job training and employment, transitional living programs, and health care especially designed for and directed at homeless youth are also needed. In the long term, homeless youth would benefit from many of the same measures that are needed to fight poverty and homelessness in the adult population, including the provision of affordable housing and employment that pays a living wage. In addition to these basic supports, the child welfare system must make every effort to prevent children from ending up on the streets.

Homeless Youth in Arizona

The number of homeless youth statewide is difficult to estimate because no one state agency collects the data. The most recent comprehensive statewide data were compiled in 1991 in a report entitled "Nowhere to Go: A Report on Runaway and Homeless Youth in Arizona." This will change as a result of SB1180 passed in 1999, which established a homeless youth intervention program. For a description of the program see Section IV, D. Current Efforts. Following is a brief description of available information.

According to the Children's Action Alliance (1999) between 5,000 and 7,000 youth live on Arizona's streets during the course of a year. The January 1999 Point-In-Time Shelter Survey* indicates that there are only 80 emergency shelter beds and 49 transitional housing beds available in Arizona for youth on their own. The Children's Action Alliance (1999) estimated that shelters turned away homeless youth 4,300 times in 1998 due to a lack of bed space. In 1996, 7,831 youth were arrested in Arizona for running away. This number represents a 51 percent increase in arrests from 1990.

***89% of homeless youth are turned away from shelter due to a lack of bed space**



Homeless Persons With a Serious Mental Illness

National Coalition for the Homeless (NCH) (April, 1999). *Homeless Persons with a Serious Mental Illness: NCH Fact Sheet #5.* [WWW document]. URL http://nch.ari.net/mental.html

Approximately 20-25% of the single adult homeless population suffers from some form of severe and persistent mental illness (Koegel et al., 1996). However, only 5% of the estimated 4 million people who have a serious mental illness are homeless at any given point in time (Federal Task Force on Homelessness and Severe Mental Illness, 1992).

Despite the disproportionate number of mentally ill people among the homeless population, the growth in homelessness is not attributable to the release of seriously mentally ill people from institutions. Most patients were released from mental hospitals in the 1950s and 1960s, yet vast increases in homelessness did not occur until the 1980s, when incomes and housing options for those living on the margins began to diminish rapidly (see "Why Are People Homeless?," NCH Fact Sheet #1). However, a new wave of deinstitutionalization and the denial of services or premature and unplanned discharge brought about by managed care arrangements may be contributing to the continued presence of seriously mentally ill persons within the homeless population.

Mental disorders prevent people from carrying out essential aspects of daily life, such as self-care, household management and interpersonal relationships. Homeless people with mental disorders remain homeless for longer periods of time and have less contact with family and friends. They encounter more barriers to employment, tend to be in poorer physical health, and have more contact with the legal system than homeless people who do not suffer from mental disorder. All people with mental disorders, including those who are homeless, require ongoing access to a full range of treatment and rehabilitation services to lessen the impairment and disruption produced by their condition. However, most people with mental disorder do not need hospitalization, and even fewer require long-term institutional care. According to the Federal Task Force on Homelessness and Severe Mental Illness, only 5-7% of homeless persons with mental illness need to be institutionalized; most can live in the community with the appropriate supportive housing options (Federal Task Force on Homelessness and Severe Mental Illness, 1992). Unfortunately, there are not enough community-based treatment services, nor enough appropriate, affordable housing, to accommodate the number of people disabled by mental disorders in the U.S.

Federal demonstration programs have produced a large body of knowledge on the service and treatment needs of homeless individuals with serious mental illnesses. Findings indicate that homeless persons with mental disorders are willing to use services that are easy to enter and that meet their perceived needs (Oakley and Dennis, 1996). Findings also reveal that persons with mental disorder and persons with addictive disorders share many of the same treatment needs, including carefully designed client engagement and case management, housing options, and long-term follow-up and support services. Studies also emphasize the importance of service integration, outreach and engagement; the use of case management to negotiate care systems; the need for a range of supportive housing and treatment options that are responsive to consumer preferences; and the importance of meaningful daily activity. When combined with supportive services, meaningful daily activity in the community (including work), and access to therapy, appropriate housing can provide the framework necessary to end homelessness for many individuals.

POLICY ISSUES

Low-income people with mental disorders are at increased risk of homelessness. A variety of approaches must be employed to help them obtain and retain stable housing to prevent homelessness.

In addition, programs that assure access to mainstream and targeted community-based services for homeless people with serious mental illness, such as the Projects for Assistance in Transition from Homelessness (PATH) program, should be expanded. At its current funding level, the PATH program is unable to meet the needs of many people with serious mental illness who are homeless or at risk of becoming homeless.

Supplemental Security Income (SSI) benefit levels must be increased so that disabled Americans are not forced to live in poverty. In 14 states and 69 metropolitan areas, the entire maximum SSI grant does not cover the Fair Market Rent for a one-bedroom apartment (Kaufman, 1997). In most states, even if the SSI grant does cover the rent, only a few dollars remain for other expenses. Benefit levels have not kept up with increases in the cost of rent and therefore do not provide disabled individuals with adequate allowances for housing.

Finally, the commitment to making deinstitutionalization work as it was intended must be renewed. People with mental illness must be able to live as independently as possible with the help of expanded comprehensive, community-based mental health services and other supports. It is crucial that polices be proactive rather than reactive. Services such as crisis intervention, landlord-tenant intervention, continuous treatment teams and appropriate discharge planning in jails and inpatient facilities must be made available in all communities.

Homeless Persons with a Serious Mental Illness in Arizona

The Arizona Homeless Coordination Office identified in a January 1999 statewide shelter survey 724 individuals believed to be seriously mentally ill by the shelter and transitional housing agencies surveyed. Of those, 406 were believed to also have substance abuse issues. Over the past several years, Regional Behavioral Health Authorities in Maricopa, Pima and Yuma Counties have applied for and received Stewart B. McKinney Homeless Assistance Act funds from the United States Department of Housing and Urban Development to provide housing and/or services for seriously mentally ill persons. At this time over 1,000 formerly homeless individuals are in McKinney funded permanent supportive housing with services provided or arranged by the behavioral system. This has had a significant impact on reducing the number of these individuals residing on the streets or in shelters. In addition, approximately 1,000 formerly homeless persons with a serious mental illness have moved from McKinney funded permanent housing to HUD Section 8 permanent housing and continue to receive supportive services. However, it is estimated that there are another 1,000-2,000 such individuals who are without permanent housing. The survey data seems to confirm this number.

Reliance on federal grant funds has become an issue in the above mentioned counties as the cost of renewing these grants can exceed the funds available for homeless programs. Homeless programs must compete for funding and it is anticipated that insufficient funds will be available to renew all existing projects, making it very difficult for any new projects to receive funding. During 1999, a Mental Health Task Force created by legislation has been meeting to review and make recommendations to improve the current mental health system in a cost-effective manner. It is expected that the issue of housing for homeless seriously mentally ill persons will be addressed in the final report of the Task Force.

Persons Suffering From Addiction Disorders

National Coalition for the Homeless (NCH) (April, 1999). *Persons Suffering From Addiction Disorders: NCH Fact Sheet #6* [WWW document]. URL http://nch.ari.net/addict.html

The relationship between homelessness and alcohol and drug addiction is quite controversial. While addictive disorders appear disproportionately among the homeless population, such disorders cannot, by themselves, explain the increase in homelessness in the 1980s. Most drug and alcohol addicts never become homeless. However, people who are poor and addicted are clearly at increased risk. In the 1970s and 80s, competition for increasingly scarce low-income housing grew so intense that those with disabilities such as addictive and mental disorders were more likely to lose out and find themselves on the streets.

PREVALENCE

Surveys of homeless populations conducted during the 1980s found consistently high rates of addiction, particularly among single men. More recent studies, however, have called the results of those studies into question. Briefly put, the studies that produced high prevalence rates greatly over-represented long-term shelter users and single men, and used lifetime rather than current measures of addiction. There is no generally accepted "magic number" with respect to the prevalence of addiction disorders among homeless adults.

RELATIONSHIP TO HOMELESSNESS

In the past, single-room-occupancy (SRO) housing housed many poor individuals, including poor persons suffering from addictive disorders and/or mental illness. From 1970 to the mid-1980s, an estimated one million SRO units were eliminated as a result of abandonment, gentrification, demolition, and conversion (Wright and Rubin, 1997). The demolition of SRO housing was most notable in large cities: between 1970 and 1982, New York City lost 87 percent of its $200-per-month-or-less SRO stock; Chicago experienced the total elimination of cubicle hotels; and by 1985, Los Angeles had lost more than half of its downtown SRO housing (Koegel et al, 1996). From 1975 to 1988, San Francisco lost 43 percent of its stock of low-cost residential hotels; from 1970 to 1986, Portland, Oregon lost 59 percent of its residential hotels; and from 1971 to 1981, Denver lost 64 percent of its SRO hotels. Thus, the destruction of SRO housing is a major factor in the growth of homelessness, particularly among people suffering from addictive disorders, in many cities.

Untreated addictive disorders do contribute to homelessness. For those with below-living wage incomes and just one-step away from homelessness, the onset or exacerbation of an addictive disorder may provide just the catalyst to plunge them into residential instability. And for people who are addicted and homeless, the health condition may be prolonged by the very life circumstance in which s/he finds her/himself. Alcohol and drug use may help meet immediate needs by providing respite from otherwise stressful and sometimes violent conditions, and thus distract from activities oriented toward stability. For people with untreated co-occurring serious mental illness, the use of alcohol and other drugs may serve as a form of self-medication. For still others, a sense of hopelessness about the future allows them to discount their addictive disorder. These explanations for addiction's sway over some homeless people should not obscure another reality - that many homeless persons with addictive disorders desire to overcome their disease, but that the combination of the homeless condition itself and a service system ill-equipped to respond to these circumstances essentially bars their access to treatment services and recovery supports.

POLICY ISSUES

There are numerous barriers to treatment and recovery opportunities. Homeless people typically do not have health insurance, including Medicaid. This means that few homeless people with addictive disorder are able to find the resources necessary to pay for their own treatment or health care. In addition, there are extensive waiting lists for addiction treatment in most states: the National Association of State Alcohol and Drug Abuse Directors estimated that in 1997, over one million people were waiting for treatment nationwide. Moreover, people who are not easy to contact, such as homeless people, are often dropped from the lists.

Other barriers to treatment include lack of transportation, lack of documentation, lack of supportive services, and abstinence-only programming. The bulk of addictive disorder treatment and recovery public policies and programs focus on abstinence as the single goal for individuals participating in programs and for the programs themselves, and in some cases forbids the alternative programs. Absolute lifetime abstinence is not a reality for the majority of people with addictive disorders; relapse is an expected occurrence in the course of treatment of the disease. Thus, this singular focus has served as a barrier to the establishment of relapse-tolerant programs, which may be more appropriate in some cases. The abstinence-only orientation also fails to recognize the other important outcomes from individual participation in addictive disorder treatment, including improved overall physical health.

Recent SSI policy changes appear to have increased homelessness among impoverished people suffering from addictive disorders. In March 1996, President Clinton signed into law legislation (P.L. 104-121) that denies Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) disability benefits and, by extension, access to Medicaid, to people whose addictions are considered to be a "contributing factor material to" the determination of their disability status. Thus far, an estimated 103,000 disabled individuals have lost their SSI or SSDI as a result of this legislation. SSI and SSDI benefits are often the only income that stands between an individual and homelessness. Furthermore, they provide access to health care through Medicaid. Preliminary results from a national study to document the effects of SSI eligibility changes for persons served by Health Care for the Homeless projects confirms the suspicion that loss of SSI and SSDI income is resulting in increased homelessness: of 681 homeless clients interviewed, 3.2% had recently lost their SSI or SSDI because of an alcohol or drug-related disability, and of those persons who had been paying for their own housing prior to losing SSI/SSDI benefits, two-thirds lost their housing because they could no longer pay for it (National Health Care for the Homeless Council, 1997).

The dominant ideas concerning addiction that have shaped public policy stand in sharp contrast to the policies recommended by many researchers and medical practitioners. While the dominant public policy approach to addictive disorders has been punitive, the most widely recommended policies developed from medical and public health perspectives focus on prevention and treatment. This is true for housed as well as homeless populations. There has been a great deal of research based on Federally funded demonstration grants on how to respond to the needs of homeless persons suffering from addiction (Oakely and Dennis, 1996). This research makes clear that housing stability is essential for successful treatment and/or recovery. When combined with supportive services, meaningful daily activity in the community (including work), and access to therapy, appropriate housing can provide the framework necessary to end homelessness for many individuals. Without a

stable place to live, recovery often remains out of reach. Regrettably, the discoveries of the demonstrations have not been widely translated to services delivery.

Despite the severity of the problem, there are currently no Federal programs that target funds to services for homeless people who have addiction disorders. The Substance Abuse Prevention and Treatment Block Grant, the main source of federal substance abuse treatment funds, does not currently target funds to homeless people. Furthermore, current programs mandated to meet the health care needs of homeless people do not have the resources necessary to address addictive disorders in a thorough manner (Cousineau, 1995). A targeted funding stream devoted to providing services to homeless people with addiction disorders would help this population overcome homelessness. In addition to targeted services, homeless people with addiction disorders need affordable housing, jobs that pay livable wages, and health care if they are to leave and remain off the streets.

Homeless Persons with Addiction Disorders in Arizona

Of those persons housed in emergency shelters and transitional housing on any given night, a large percentage are identified by shelter staff as having a substance abuse issue. Based on a January 1999 survey, 34 percent of the adults in families were believed to have substance abuse issues, including a small number who also were believed to be seriously mentally ill. Among the single adult population, almost 73 percent were reported to have substance abuse problems with 17 percent of those adults also having reported serious mental illness. This does not mean that such a high percentage of all homeless persons have substance abuse problems. National studies have shown that this population is over represented in shelter populations. Those persons without such issues tend to remain homeless for shorter periods of time and thus are less likely to be counted during point-in-time surveys. Thus, during the course of a year, the percentage of homeless persons with substance abuse issues is significantly lower.

The Arizona Department of Corrections estimates that 80 percent of offenders released from Arizona prisons have addiction issues. Over 1,200 offenders are released to supervision without housing. Many of them turn to urban shelters as their source of housing. Without adequate housing and treatment these individuals are more likely to re-offend at a high financial and social cost to the community.

Adequately addressing the needs of the addicted homeless population is a high priority in most communities in the state that identified their homelessness issues and needs as part of the Continuum of Care planning process required by the Department of Housing and Urban Development. Substance abuse funding from state and federal sources in Arizona is extremely inadequate to address the needs. For example, Maricopa County, the largest county in the state, has a total of 32 publicly funded detoxification beds and the number of residential treatment beds has been decreasing due to a lack of adequate funding. Many rural areas of the state have no detoxification services available and little or no treatment that is accessible to homeless and low-income persons.

Homeless Veterans

National Coalition for the Homeless (NCH) (April, 1999). *Homeless Veterans: NCH Fact Sheet #9.* [WWW document]. URL http://nch.ari.net/veterans.html

BACKGROUND

Approximately 40% of homeless men are veterans, although veterans comprise only 34% of the general adult male population. The National Coalition for Homeless Veterans estimates that on any given night, 271,000 veterans are homeless (National Coalition for Homeless Veterans, 1994).

Despite the overrepresentation of veterans in the homeless population, homelessness among veterans is not clearly related to combat military experience. Rather, studies show that homeless veterans appear less likely to have served in combat than housed veterans (Rosenheck, 1996).

Similarly, despite the widespread perception that Vietnam-era veterans constitute the majority of homeless veterans, research indicates that the veterans who are at greatest risk of homelessness are those who served during the late Vietnam and post-Vietnam era (Rosenheck, 1996). These veterans had little exposure to combat, but appear to have increased rates of mental illness and addiction disorders, possibly due to recruitment patterns. Faced with a lack of affordable housing, declining job opportunities, and stagnating wages (see "Why are People Homeless?," NCH Fact Sheet #1), people with these disabilities are more vulnerable to homelessness.

DEMOGRAPHICS

Homeless veterans are more likely to be white, better educated, and previously or currently married than homeless nonveterans (Rosenheck, 1996).

Female homeless veterans represent an estimated 1.6% of homeless veterans. They are more likely than male homeless veterans to be married and to suffer serious psychiatric illness, but less likely to be employed and to suffer from addiction disorders. Comparisons of homeless female veterans and other homeless women have found no differences in rates of mental illness or addictions.

Minorities are overrepresented among homeless veterans, just as they are among the homeless population in general. However, there is some evidence that veteran status reduces vulnerability to homelessness among Black Americans. Black nonveterans are 2.9 times more likely to be homeless than white nonveterans; Black veterans, on the other hand, are 1.4 times more likely to be homeless than white veterans (Rosenheck, 1996). The reduced risk of homelessness among Black veterans is most likely the result of educational and other benefits to which veterans are entitled, and thereby provides indirect evidence of the ability of government assistance to reduce homelessness.

PROGRAMS AND POLICY ISSUES

The U.S. Department of Veterans Affairs (VA) administers two special programs for homeless veterans: the Domiciliary Care for Homeless Veterans program (DCHV) and the Health Care for Homeless Veterans program (HCHV). Both programs provide outreach, psychosocial assessments, referrals, residential treatments, and follow-up case management to homeless veterans. Recent evaluations have found that these programs significantly improve homeless veterans' housing, psychiatric status, employment, and access to health services (Friesman et al., 1996; U.S. Department of Veterans Affairs, 1995). In addition, the VA has initiated several new programs for

homeless veterans and has expanded partnerships with public, private, and non-profit organizations to expand the range of services for homeless veterans (U.S. Department of Veterans Affairs, 1997).

In 1995, the VA conducted a national survey of VA homeless programs and community organizations to identify needs of homeless veterans. The survey found that long-term permanent housing, dental care, eye care, and child care were the greatest unmet needs of homeless veterans (U.S. Department of Veterans Affairs, 1995). Similarly, participants in a National Summit on Homelessness Among Veterans sponsored by the VA identified the top priority areas as jobs, preventing homelessness, housing, and substance abuse/mental health treatment (U.S. Department of Veterans Affairs, 1997).

In general, the needs of homeless veterans do not differ from those of other homeless people. There is some evidence, however, that programs which recognize and acknowledge veteran experience may be more successful in helping homeless veterans transition into stabile housing. Until serious efforts are made to address the underlying causes of homelessness, including inadequate wages, lack of affordable housing, and lack of accessible, affordable health care, the tragedy of homelessness among both veterans and nonveterans will continue to plague American communities.

Homeless Veterans in Arizona

In Arizona there are a small number of private-non-profit transitional housing programs for veterans that provide approximately 100 beds. In addition, the U.S. Department of Veterans Affairs provides medical care for veterans in Phoenix, Tucson and Prescott. Homeless veterans are served at each of these three locations. In 1999 Arizona established a Department of Veterans Services. The director of this new department has met with advocates for homeless veterans to hear their concerns and recommendations regarding the needs of homeless veterans.

Currently, many emergency shelters and transitional housing programs do not collect information on the veteran status of the adults they serve. However, data collected in a 1996 survey of homeless persons in the Phoenix area found that 25.4 percent reported military service (Johnson, R. M. (1997). A Snapshot of Homeless People in Phoenix. Phoenix: Arizona State University, Morrison Institute for Public Policy, School of Public Affairs). A 1997-1998 survey in Tucson found that 39 percent of homeless persons surveyed were veterans (Snow, D. A., & Shockey, J. (1998). Report on Tucson's Homeless Population 1997-1998. Tucson: University of Arizona, Department of Sociology).

Victims of Domestic Violence

National Coalition for the Homeless (NCH) (April, 1999). *Victims of Domestic Violence: NCH Fact Sheet #8* [WWW document]. URL http://nch.ari.net/domestic.html

BACKGROUND

When a woman leaves an abusive relationship, she often has nowhere to go. This is particularly true of women with few resources. Lack of affordable housing and long waiting lists for assisted housing mean that many women and their children are forced to choose between abuse at home or the streets. Moreover, shelters are frequently filled to capacity and must turn away battered women and their children. An estimated 32% of requests for shelter by homeless families were denied in 1998 due to lack of resources (U.S. Conference of Mayors, 1998).

DOMESTIC VIOLENCE AS A CONTRIBUTING FACTOR TO HOMELESSNESS

Many studies demonstrate the contribution of domestic violence to homelessness, particularly among families with children. A 1990 Ford Foundation study found that 50% of homeless women and children were fleeing abuse (Zorza, 1991). More recently, in a study of 777 homeless parents (the majority of whom were mothers) in ten U.S. cities, 22% said they had left their last place of residence because of domestic violence (Homes for the Homeless, 1998). In addition, 46% of cities surveyed by the U.S. Conference of Mayors identified domestic violence as a primary cause of homelessness (U.S. Conference of Mayors, 1998). State and local studies also demonstrate the impact of domestic violence on homelessness:

- *In Minnesota, the most common reason for women to enter a shelter is domestic violence. Approximately one in five women (19%) surveyed indicated that one of the main reasons for leaving housing was to flee abuse; 24% of women surveyed were homeless, at least in part, because of a previous abuse experience (Wilder Research Center, 1998).*

- *In Missouri, 18% of the sheltered homeless population are victims of domestic violence (De Simone et al., 1998).*

- *A 1995 survey of homeless adults in Michigan found that physical abuse/being afraid of someone was most frequently cited as the main cause of homelessness (Douglass, 1995).*

- *Shelter providers in Virginia report that 35% of their clients are homeless because of family violence (Virginia Coalition for the Homeless, 1995). This same survey found that more than 2,000 women seeking shelter from domestic violence facilities were turned away.*

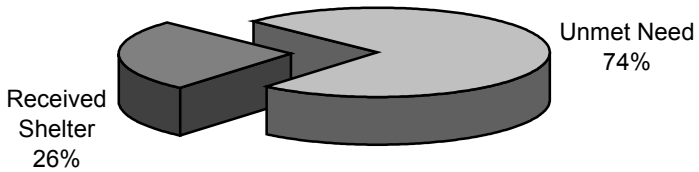
POLICY ISSUES

Shelters provide immediate safety to battered women and their children and help women gain control over their lives. The provision of safe emergency shelter is thus a necessary first step in meeting the needs of women fleeing domestic violence.

A sizable portion of the welfare population experiences domestic violence at any given time; thus, without significant housing support, many welfare recipients are at risk of homelessness or continued violence. In states that have looked at domestic violence and welfare receipt, most report that approximately 50-60% of current recipients say that they have experienced violence from a current or former male partner (Institute for Women's Policy Research, 1997). In the absence of cash assistance, women who experience domestic violence may be at increased risk of homelessness or compelled to live with a former or current abuser in order to prevent homelessness. Welfare programs must make every effort to assist victims of domestic violence and to recognize the tremendous barrier to employment that domestic violence presents.

Long term efforts to address homelessness must include increasing the supply of affordable housing, ensuring adequate wages and income supports, and providing necessary supportive services.

Domestic Violence in Arizona



A January 27, 1999 Point-In-Time Survey of homeless shelters statewide indicated that 15% of those in shelter came from a domestic violence situation. Between July 1, 1998 and June 30, 1999, staff and volunteers in 30 residential shelters and safe home networks in the State of Arizona responded to 20,436 family violence telephone calls and 14,619 crisis (i.e., sexual assault, suicide, etc.) telephone calls. Crisis counseling and shelter were provided to 6,942 women and children who received 127,479 nights of emergency shelter and 79,184 hours of residential counseling. Non-residential counseling/advocacy was provided to victims of domestic violence. 3,193 women and children received individual counseling and 3,998 participated in group counseling. Of those programs reporting, offender treatment was provided to 3,790 perpetrators. During the year 26,717 women and children requested shelter, which was unavailable to 19,775 of them. The majority of those who received shelter, 62%, stayed 1-14 days, 19.6% stayed 15-30 days, and 18.5% stayed 31-90 days. Almost half, 49.6% of these women and children were White, 25.2% Hispanic, 12.4% native American, 9.6% Black, 1.6 Asian, and 1.6% other. The Arizona Coalition Against Domestic Violence reports 40 domestic violence related homicides in 1998.

C. Why Are People Homeless?

"Homelessness does not happen in a vacuum. There is no one thing that causes homelessness and there will be no one thing that solves it." –Zenobia Embry Nimmer

The following selection is an excerpt of an article that was published by the National Coalition for the Homeless on its webpage. The boxes containing Arizona statistics were inserted by the DES Homeless Coordination Office.

National Coalition for the Homeless (NCH) (April, 1999). *Why Are People Homeless?: NCH Fact Sheet #1*. [WWW document]. URL http://nch.ari.net/causes.html

Two trends are largely responsible for the rise in homelessness over the past 15-20 years: a growing shortage of affordable rental housing and a simultaneous increase in poverty. Below is an overview of current poverty and housing statistics, as well as additional factors contributing to homelessness. A list of resources for further study is also provided.

POVERTY

Homelessness and poverty are inextricably linked. Poor people are frequently unable to pay for housing, food, child care, health care, and education. Difficult choices must be made when limited resources cover only some of these necessities. Often it is housing, which absorbs a high proportion of income, that must be dropped. Being poor means being an illness, an accident, or a paycheck away from living on the streets.

In 1997, 13.3% of the U.S. population, or 35.6 million people, lived in poverty (U.S. Bureau of the Census, 1998a). While the number of poor people has not changed much in recent years, the number of people living in extreme poverty has increased. In 1997, 14.6 million people -- 41% of all poor persons -- had incomes of less than half the poverty level. This represents an increase of over 500,000 from 1995. Forty percent of persons living in poverty are children; in fact, the 1997 poverty rate of 19.9% for children is almost twice as high as the poverty rate for any other age group.

Two factors help account for increasing poverty: eroding employment opportunities for large segments of the workforce, and the declining value and availability of public assistance.

Eroding Work Opportunities

Media reports of a growing economy and low unemployment mask a number of important reasons why homelessness persists, and, in some areas of the country, is worsening. These reasons include stagnant or falling incomes and less secure jobs which offer fewer benefits.

While the last few years have seen growth in real wages at all levels, these increases have not been enough to counteract a long pattern of stagnant and declining wages. Low-wage workers have been particularly hard hit by wage trends. Despite recent increases in the minimum wage, the real value of the minimum wage in 1997 was 18.1% less than in 1979 (Mishel, Bernstein, and Schmitt, 1999). Factors contributing to wage declines include a steep drop in the number and bargaining power of unionized workers; erosion in the value of the minimum wage; a decline in manufacturing jobs and the corresponding expansion of lower-paying service-sector employment; globalization; and increased nonstandard work, such as temporary and part-time employment (Mishel, Bernstein, and Schmitt, 1999).

Declining wages, in turn, have put housing out of reach for many workers: in every state, more than the minimum wage is required to afford a one- or two-bedroom apartment at Fair Market Rent (National Low Income Housing Coalition, 1998).[1] In fact, in the median state a minimum-wage worker would have to work 87 hours each week to afford a two-bedroom apartment at 30% of his or her income, which is the federal definition of affordable housing. In addition, 40% of households with "worst case housing needs" -- households paying over half their incomes for rent, living in severely substandard housing, or both -- have at least one working person. This represents a 32% increase in working households with worst case housing needs from 1993 to 1995 (U.S. Housing and Urban Development, 1998).

The connection between impoverished workers and homelessness can be seen in homeless shelters, many of which house significant numbers of full-time wage earners. A survey of 30 U.S. cities found that almost one in five homeless persons is employed (U.S. Conference of Mayors, 1998). In a number of cities not surveyed by the U.S. Conference of Mayors - as well as in many states - the percentage is even higher (National Coalition for the Homeless, 1997).

The future of job growth does not appear promising for many workers: a 1998 study estimated that 46% of the jobs with the most growth between 1994 and 2005 pay less than $16,000 a year; these jobs will not lift families out of poverty (National Priorities Project, 1998).[2] Moreover, 74% of these jobs pay below a livable wage ($32,185 for a family of four).

Thus, for many Americans, work provides no escape from poverty. The benefits of economic growth have not been equally distributed; instead, they have been concentrated at the top of income and wealth distributions. A rising tide does not lift all boats, and in the United States today, many boats are struggling to stay afloat.

Poverty in Arizona

An estimated 18.4 percent of Arizona residents fell below the federal poverty level in 1998. A living wage for a family of four in Arizona is $32,391 per year. Eighty-eight percent of the fastest growing jobs in Arizona pay below a livable wage (National Priorities Project analysis of Bureau of Statistics data). The Center on Budget and Policy Priorities in a recent published study, "Pulling Apart: A State-by State Analysis of Income Trends" reported that Arizona has one of the widest income gaps between the top 20 percent and bottom 20 percent of families. The report states that "Arizona has one of the widest income gaps and the gap is widening faster than in other states. In Arizona, real incomes of the bottom fifth fell by 37.2 percent over the decade. Middle income families saw their inflation-adjusted wages fall by nearly 21 percent. Those are the largest declines of any state in the nation." Such low incomes for the bottom fifth of the households in Arizona coupled with rising housing costs that exceed that rate of income gains places increasing pressures on those households that are precariously housed.

Decline in Public Assistance

The declining value and availability of public assistance is another source of increasing poverty and homelessness. Until its repeal in August 1996, the largest cash assistance program for poor families with children was the Aid to Families with Dependent Children (AFDC) program. Between 1970 and 1994, the typical state's AFDC benefits for a family of three fell 47%, after adjusting for inflation (Greenberg and Baumohl, 1996). The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the federal welfare reform law) repealed the AFDC program and replaced it with a block grant program called Temporary Assistance to Needy Families (TANF). Current TANF benefits and Food Stamps combined are below the poverty level in every state; in fact, the median TANF benefit for a family of three is approximately one-third of the poverty level. Thus, contrary to popular opinion, welfare does not provide relief from poverty…

As a result of loss of benefits, low wages, and unstable employment, many families leaving welfare struggle to get medical care, food, and housing. Many lose health insurance, despite continued Medicaid eligibility: a recent study found that 675,000 people lost health insurance in 1997 as a result of the federal welfare reform legislation, including 400,000 children (Families USA, 1999). In addition, housing is rarely affordable for families leaving welfare for low wages, yet subsidized housing is so limited that fewer than one in four TANF families nationwide lives in public housing or receives a housing voucher to help them rent a private unit. For most families leaving the rolls, housing subsidies are not an option. In some communities, former welfare families appear to be experiencing homelessness in increasing numbers (Children's Defense Fund and the National Coalition for the Homeless, 1998).

In addition to the reduction in the value and availability of welfare benefits for families, recent policy changes have reduced or eliminated public assistance for poor single individuals. Several states have

cut or eliminated General Assistance (GA) benefits for single impoverished people, despite evidence that the availability of GA reduces the prevalence of homelessness (Greenberg and Baumohl, 1996).

Disabled people, too, must struggle to obtain and maintain stable housing. In 1998, on a national average, a person receiving Supplemental Security Income (SSI) benefits had to spend 69% of his or her SSI monthly income to rent a one-bedroom apartment at Fair Market Rent; in more than 125 housing market areas, the cost of a one-bedroom apartment at Fair Market Rent was more than a person's total monthly SSI income (Technical Assistance Collaborative & the Consortium for Citizens with Disabilities Housing Task Force, 1999).

Thus, most states have not replaced the old welfare system with an alternative that enables families and individuals to obtain above-poverty employment and to sustain themselves when work is not available or possible.

Public Assistance in Arizona

A recently published report, "Arizona Cash Assistance Exit Study" (January 2000, Westra and Routley) provides considerable information on the status of households that left Arizona welfare rolls during the months of January 1998 through March 1998. The study received completed surveys from stratified random samples of 405 individuals that left cash assistance due to a sanction and 416 individuals that left for other reasons, including employment. The survey data indicated that 57 percent of the respondents were working. The average wage earnings of the working households was $821 per month while total household income, including take home pay, take home pay of other adults in the household, cash assistance, food stamps, child support, social security and general assistance was $1,439 per month.

All survey participants were asked questions regarding measures of well being for the period while they were receiving cash assistance and after they stopped receiving cash assistance. A slightly smaller percentage of families reported being behind in housing costs (37% vs. 41%), being forced to move because of inability to pay for housing (17% vs. 21%), or forced into a homeless shelter after they left cash assistance (3% vs. 4%). A smaller percentage of families also reported receiving subsidized housing (18% vs. 21%) and subsidized utility payments (11% vs. 20%), while a higher percentage reported receiving free housing from relatives after leaving cash assistance (26% vs. 23%). Living with relatives is a risk factor for future homelessness, but these families had not yet reported increased rates of homelessness at the time of the survey. Overall, 15% of the families reported being worse off after cash assistance stopped.

HOUSING

A lack of affordable housing and the limited scale of housing assistance programs have contributed to the current housing crisis and to homelessness.

The gap between the number of affordable housing units and the number of people needing them has created a housing crisis for poor people. Between 1973 and 1993, 2.2 million low-rent units disappeared from the market. These units were either abandoned, converted into condominiums or expensive apartments, or became unaffordable because of cost increases. Between 1991 and 1995,

median rental costs paid by low-income renters rose 21%; at the same time, the number of low-income renters increased. Over these years, despite an improving economy, the affordable housing gap grew by one million (Daskal, 1998). By 1995, the number of low-income renters in America outstripped the number of low-cost rental units by 4.4 million rental units - the largest shortfall on record (Daskal, 1998). More recently, the strong economy has caused rents to soar, putting housing out of reach for the poorest Americans. Between 1995 and 1997, rents increased faster than income for the 20% of American households with the lowest incomes (U.S. Department of Housing and Urban Development, 1999). This same study found that the number of housing units that rent for less than $300, adjusted for inflation, declined from 6.8 million in 1996 to 5.5 million in 1998, a 19 percent drop of 1.3 million units. The loss of affordable housing puts even greater numbers of people at risk of homelessness.

The lack of affordable housing has lead to high rent burdens (rents which absorb a high proportion of income), overcrowding, and substandard housing. These phenomena, in turn, have not only forced many people to become homeless; they have put a large and growing number of people at risk of becoming homeless. A recent Housing and Urban Development (HUD) study found that 5.3 million unassisted, very low-income households had "worst case needs" for housing assistance in 1995 (U.S. Department of Housing and Urban Development, 1998).[3] This figure is an all-time high and represents an 8% increase over the 1989 figure.

Housing assistance can make the difference between stable housing, precarious housing, or no housing at all. However, the demand for assisted housing clearly exceeds the supply: only about one-third of poor renter households receive a housing subsidy from the federal, state, or a local government (Daskal, 1998). The limited level of housing assistance means that most poor families and individuals seeking housing assistance are placed on long waiting lists. From 1996-1998, the time households spent on waiting lists for HUD housing assistance grew dramatically. For the largest public housing authorities, a family's average time on a waiting list rose from 22 to 33 months from 1996 to 1998 - a 50% increase (U.S. Department of Housing and Urban Development, 1999). The average waiting period for a Section 8 rental assistance voucher rose from 26 months to 28 months between 1996 and 1998.[4] Excessive waiting lists for public housing mean that people must remain in shelters or inadequate housing arrangements longer. Consequently, there is less shelter space available for other homeless people, who must find shelter elsewhere or live on the streets.

A housing trend with a particularly severe impact on homelessness is the loss of single room occupancy (SRO) housing. In the past, SRO housing served to house many poor individuals, including poor persons suffering from mental illness or substance abuse. From 1970 to the mid-1980s, an estimated one million SRO units were demolished (Dolbeare, 1996). The demolition of SRO housing was most notable in large cities: between 1970-1982, New York City lost 87% of its $200 per month or less SRO stock; Chicago experienced the total elimination of cubicle hotels; and by 1985, Los Angeles had lost more than half of its downtown SRO housing (Koegel, et al, 1996). From 1975 to 1988, San Francisco lost 43% of its stock of low-cost residential hotels; from 1970 to 1986, Portland, Oregon lost 59% of its residential hotels; and from 1971 to 1981, Denver lost 64% of its SRO hotels (Wright and Rubin, 1997). Thus the destruction of SRO housing is a major factor in the growth of homelessness in many cities.

Finally, it should be noted that the largest federal housing assistance program is the entitlement to deduct mortgage interest from income for tax purposes. In fact, for every one dollar spent on low income housing programs, the federal treasury loses four dollars to housing-related tax expenditures, 75% of which benefit households in the top fifth of income distribution (Dolbeare, 1996). Moreover, in 1994 the top fifth of households received 61% of all federal housing benefits (tax and direct), while the bottom fifth received only 18%. Thus, federal housing policy has thus not responded to the needs of low-income households, while disproportionately benefitting the wealthiest Americans.

Housing in Arizona

The Governor of Arizona created an Arizona Housing Commission by Executive Order in 1996. Its mission was to serve as an advisory body to the Governor, the Legislature and the Arizona Department of Commerce, which is the primary agency responsible for housing programs. In 1997, the passage of House Bill 2011 established the Arizona Housing Commission in Statute. In September 1999 the Commission published a draft report, "The State of Housing in Arizona". This report provides an excellent source of information regarding the status of affordable housing in Arizona. The following information is excerpted from the draft report:

- Thirty percent of income is the commonly accepted maximum amount that a family should pay for housing and utilities. Housing expenses above 30 percent limit a household's ability to pay for other basic needs such as food, clothing, child care, education and health care. The table below shows what households with various incomes can afford based on the 30 percent guideline. The median household income in Arizona is not sufficient to afford a 95 percent loan on a median priced home, despite low interest rates. In addition, two people living together and each earning the minimum wage cannot afford to rent a median priced apartment.

- Without an increase in income levels or housing affordability, some type of direct housing subsidies from either private or public sources is the only way for families with incomes too low to qualify for a home or benefit from tax deductions, to be treated equally. Unfortunately, there are a large number of households in Arizona who do not receive public housing assistance and lack the income or resources to obtain homeownership.

Housing Affordability by Income Level, 1998
(Based on 30 Percent Income)

	Income or Wage Level	Maximum Affordable Monthly Housing Expense
State Median Household Income	$34,268	$857
Livable Wage (4 Persons)	$32,400	$810
Services Job Sector (avg. wage)	$25,868	$647
Minimum Wage (2 workers)	$21,840	$546
Retail Job Sector (avg. wage)	$17,380	$435
Poverty Level (4 persons)	$16,813	$420
Minimum wage (1 worker)	$10,920	$273

Source: U. S. Census Bureau, Arizona Department of Commerce; PCensus; National Priorities Project; Arizona Department of Economic Security, 1998 estimates.

- Arizona is facing an impending housing affordability crisis. Housing prices and rent in Arizona are growing much faster than incomes. Statewide, housing prices are rising twice as fast as income.

- In 1998 only 62% of Arizona households had adequate income to be able to afford the median rent and utilities.

- Public Housing Authorities in Arizona (PHA) report waiting lists totaling 43,000 households, twice the number of households currently being served. The average waiting period is two to three years. Many PHAs have stopped accepting applications.

- According to 1998 Indian Housing Plans, it is conservatively estimated that 29,916 housing units are needed on tribal lands.

- Included in the Arizona Housing Commission report are many recommendations. Three of the recommendations are:

1. Improve the ability of housing providers to develop a mix of affordable housing;
2. Provide housing and support services for Arizona's growing special-needs populations;
3. Promote and expedite affordable housing development on Native American reservations.

OTHER FACTORS

Particularly within the context of poverty and the lack of affordable housing, certain additional factors may push people into homelessness. Other major factors which can contribute to homelessness include the following:

Lack of Affordable Health Care

For families and individuals struggling to pay the rent, a serious illness or disability can start a downward spiral into homelessness, beginning with a lost job, depletion of savings to pay for care, and eventual eviction. In 1997, approximately 43.4 million Americans had no health care insurance (U.S. Bureau of the Census, 1998b). More than a third of persons living in poverty had no health insurance of any kind. The coverage held by many others would not carry them through a catastrophic illness.

Domestic Violence

Battered women who live in poverty are often forced to choose between abusive relationships and homelessness. In a study of 777 homeless parents (the majority of whom were mothers) in ten U.S. cities, 22% said they had left their last place of residence because of domestic violence (Homes for the Homeless, 1998). In additions, 46% of cities surveyed by the U.S. Conference of Mayors identified domestic violence as a primary cause of homelessness (U.S. Conference of Mayors, 1998).

Mental Illness

Approximately 20-25% of the single adult homeless population suffer from some form of severe and persistent mental illness (Koegel et al, 1996). Despite the disproportionate number of severely mentally ill people among the homeless population, increases in homelessness are not attributable to the release of severely mentally ill people from institutions. Most patients were released from mental hospitals in the 1950s and 1960s, yet vast increases in homelessness did not occur until the 1980s, when incomes and housing options for those living on the margins began to diminish rapidly. According to the Federal Task Force on Homelessness and Severe Mental Illness, only 5-7% of homeless persons with mental illness need to be institutionalized; most can live in the community

with the appropriate supportive housing options (Federal Task Force on Homelessness and Severe Mental Illness, 1992). However, many mentally ill homeless people are unable to obtain access to supportive housing and/or other treatment services. The mental health support services most needed include case management, housing, and treatment.

Addiction Disorders

The relationship between addiction and homelessness is complex and controversial. While rates of alcohol and drug abuse are disproportionately high among the homeless population, the increase in homelessness over the past two decades cannot be explained by addiction alone. Many people who are addicted to alcohol and drugs never become homeless, but people who are poor and addicted are clearly at increased risk of homelessness. During the 1980s, competition for increasingly scarce low-income housing grew so intense that those with disabilities such as addiction and mental illness were more likely to lose out and find themselves on the streets. The loss of SRO housing, a source of stability for many poor people suffering from addiction and/or mental illness, was a major factor in increased homelessness in many communities.

Addiction does increase the risk of displacement for the precariously housed; in the absence of appropriate treatment, it may doom one's chances of getting housing once on the streets. Homeless people often face insurmountable barriers to obtaining health care, including addictive disorder treatment services and recovery supports. The following are among the obstacles to treatment for homeless persons: lack of health insurance; lack of documentation; waiting lists; scheduling difficulties; daily contact requirements; lack of transportation; ineffective treatment methods; lack of supportive services; and cultural insensitivity. An in-depth study of 13 communities across the nation revealed service gaps in every community in at least one stage of the treatment and recovery continuum for homeless people (National Coalition for the Homeless, 1998).

Even when disabling conditions such as addiction or mental illness are treated, homeless addicts and mentally ill people must compete with all other poor people for a dwindling supply of low-income housing. Homelessness can thus be seen as a perverse game of musical chairs, in which the loss of "chairs" (low cost housing) forces some people to be left standing (homeless). Those who are least able to secure a chair -- the most disabled and therefore the most vulnerable -- are more likely to be left without a place to sit.

CONCLUSION

Homelessness results from a complex set of circumstances which require people to choose between food, shelter, and other basic needs. Only a concerted effort to ensure jobs that pay a living wage, adequate support for those who cannot work, affordable housing, and access to health care will bring an end to homelessness.

FOOTNOTES

1. FMRs are the monthly amounts "needed to rent privately owned, decent, safe, and sanitary rental housing of a modest (nonluxury) nature with suitable amenities." Federal Register. HUD determines FMRs for localities in all 50 states. [Back].

2.The poverty line for a family of three is $12,750; for a family of four, the poverty line is $16,813. See http://www.census.gov/hhes/ww w/poverty.html for details.[Back].

3."Worst case needs" refers to those renters with incomes below 50% of the area median income who are involuntarily displaced, pay more than half of their income for rent and utilities, or live in substandard housing. [Back].

4.The Section 8 Program is a federal housing assistance program that provides housing subsidies for families and individuals to live in existing rental housing or in designated housing projects. [Back].

III. Status of Homelessness Nationwide and in Arizona

A. How many people experience homelessness?

National Alliance to End Homelessness (NAEH) (n.d/1998). *Facts About Homelessness.* [WWW document]. URL http://www.naeh.org/back/factsus.htm

750,000 Americans are homeless on any given night. Over the course of a year, as many as two million people experience homelessness for some period of time. These are the people who live on the street, in shelters, in cars, and in campgrounds. Millions more live in precarious situations-over-crowded with family or friends, housed temporarily in institutions like prisons or mental hospitals, or paying too much of their income for rent. Together, all of these individuals make up the pool from which people cycle in and out of homelessness.

Nationwide

National Coalition for the Homeless (NCH) (February, 1999). *How Many People Experience Homelessness?: NCH Fact Sheet #2.* [WWW document]. URL http://nch.ari.net/numbers.html

Summary of National Estimates

METHOD	YEAR(S)	ESTIMATE
Point-In-Time Survey	1988	500,000-600,000
Projected Rate Update	1999	700,000+/night; 2million/year
Telephone Survey	1985-1990	7,000,000
Turnover Rates	1994	3%

IS HOMELESSNESS INCREASING?

One limited measure of the growth in homelessness is the increase in the number of shelter beds over time. A 1991 study examined homelessness "rates" (the number of shelter beds in a city divided by the city's population) in 182 U.S. cities with populations over 100,000. The study found that homelessness rates tripled between 1981 and 1989 for the 182 cities as a group (Burt, 1997).

A 1997 review of research conducted over the past decade (1987-1997) in 11 communities and 4 states found that shelter capacity more than doubled in nine communities and three states during that time period (National Coalition for the Homeless, 1997). In two communities and two states, shelter capacity tripled over the decade.

These numbers are useful for measuring the growth in demand for shelter beds (and the resources made available to respond to that growth) over time. They indicate a dramatic increase in homelessness in the United States over the past two decades.

Arizona

Continuum of Care Gaps Analysis

The Continuum of Care is the Department of Housing and Urban Development's primary strategy to reduce homelessness. The Continuum of Care process is an approach to local decision making which brings relevant community groups including units of local government, state government, non-profit agencies, charitable organizations, the faith community, housing developers, corporations, neighborhood groups, homeless and formerly homeless people and others together to address the issue of homelessness at the local level.

The Continuum of Care Gaps Analysis is the part of this process in which communities' come together to identify gaps in the local response to homelessness and then set priorities to fill those gaps. To identify gaps in the Continuum of Care, the number of homeless people, type and number of services, and type and number of unmet needs are generated. In Arizona, gaps analyses are conducted in each county on a yearly basis.

The table below shows the estimated number of homeless individuals in each county on a given day in 1998-1999, as determined by a local gaps analysis process.

Estimated Number of People Who Experienced Homelessness at a Point-In-Time

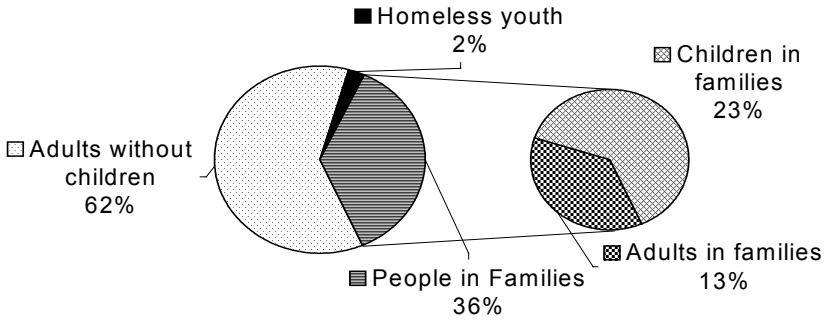
COUNTY	1998-1999		
	Individuals	Persons in Families with Children	TOTAL
Apache	75	150	**225**
Cochise	114	120	**234**
Coconino	1,000	1,000	**2,000**
Gila	125	140	**265**
Graham/Greenlee	75	75	**150**
La Paz	70	83	**153**
Maricopa	8,828	3,153	**11,981**
Mohave	1,200	600	**1,800**
Navajo	400	175	**575**
Pima	2,400	2,100	**4,500**
Pinal	165	341	**506**
Santa Cruz	100	100	**200**
Yavapai	1,750	800	**2,550**
Yuma	694	837	**1,531**
Total	**16,996**	**9,674**	**26,670**

Point-In-Time Survey: January 27, 1999

On January 27, 1999, all shelter and transitional housing programs in Arizona known to the DES Homeless Coordination Office were asked to report on how many homeless people were housed that night, what their characteristics were, and how many people were denied assistance on that night.

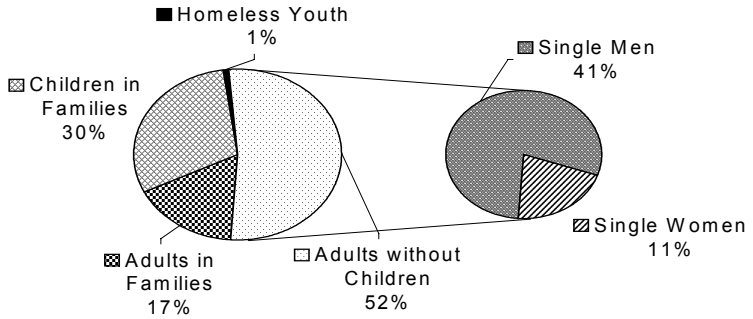
Other information requested included estimates of how many of the housed homeless persons had drug or alcohol dependency, serious mental illness, drug or alcohol issues combined with a serious mental illness (dual diagnosis), domestic violence issues, or AIDS/related diseases. A summary of the data follows:

People in Emergency Shelter on January 27, 1999

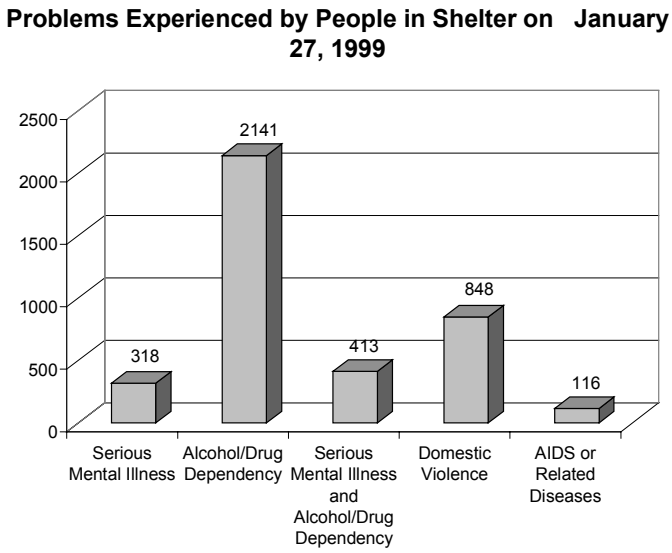


January 27, 1999, 2,466 people including 1,477 adults without children, 273 families, and 58 homeless youth stayed in emergency shelter in Arizona. In those 273 families, 322 were adults and 599 were children.

People in Transitional Housing on January 27, 1999



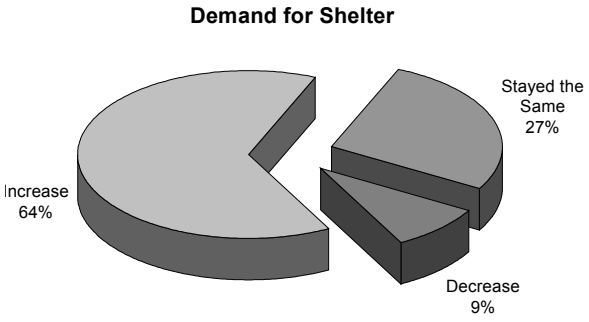
On January 27, 1999, 3,082 people including 1,615 adults without children, 488 families, and 32 homeless youth stayed in transitional housing in Arizona. In those 488 families, 511 were adults and 924 were children.



This chart shows the number of homeless persons, of a total of 5,548 who were in emergency shelter or transitional housing on January 27, 1999, who experienced a given problem. While the first three categories are mutually exclusive, a person can only fit into one of them, it is possible for a person to experience one of the first three problems and one or both of the last two (domestic violence and or AIDS/related diseases).

Of 125 agencies that responded to the question regarding requests for shelter, 80 stated that requests for shelter had increased compared to the same time last year, 34 stated that the demand was the same, and 11 reported a decrease.

Agencies reported that on January 27, 1999, they had to turn away 167 individuals and 168 families that requested assistance. Allowing 3.1 persons per family, based on actual counts in shelter, and for 15 percent duplication, this translates to an estimated 585 individuals denied shelter in one day in the State of Arizona.

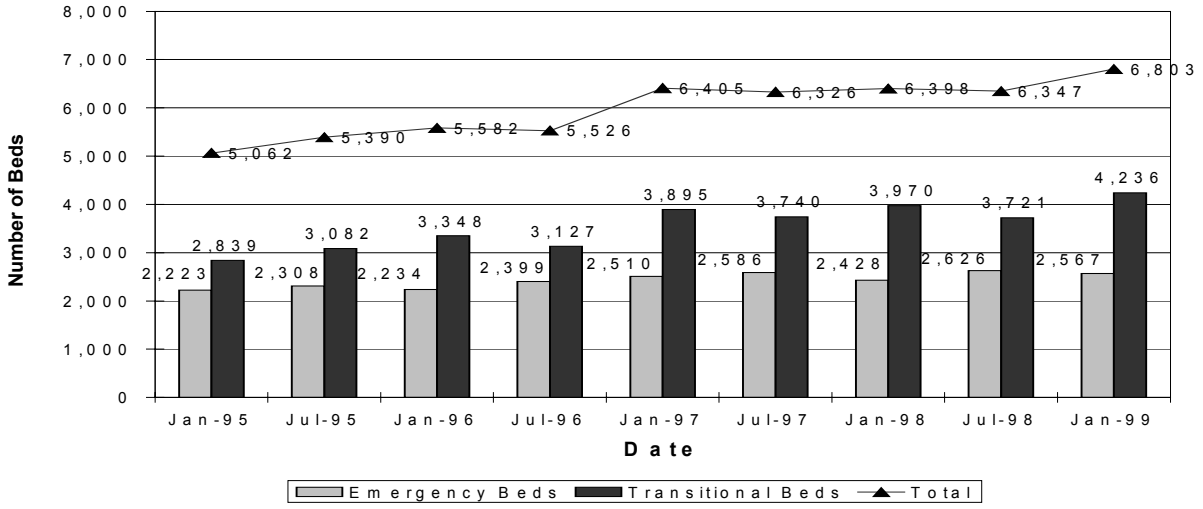


Statewide Shelter Survey: Nine Survey Comparison

The State Homeless Coordination Office has completed a statewide shelter and motel voucher survey semi-annually since 1995. Responses to this survey are sought from all known agencies throughout that shelter homeless people. Requests to complete surveys are sent to over 150 agencies in Arizona that provide shelter or motel vouchers. Responses are usually received from 90 percent of these agencies. The agencies surveyed establish their own parameters for the type of clients served and intake qualifications. Therefore, the range of people counted in this survey is limited by the type of shelter. This should be considered before drawing conclusions about the homeless population in Arizona. Regarding "unused capacity", particularly as it relates to family shelter, it should be noted that capacity of shelter units (rooms, apartments, etc.) is average or maximum figures. For example, an agency may have three four-bed apartments occupied by three families with eight people, leaving four beds unoccupied.

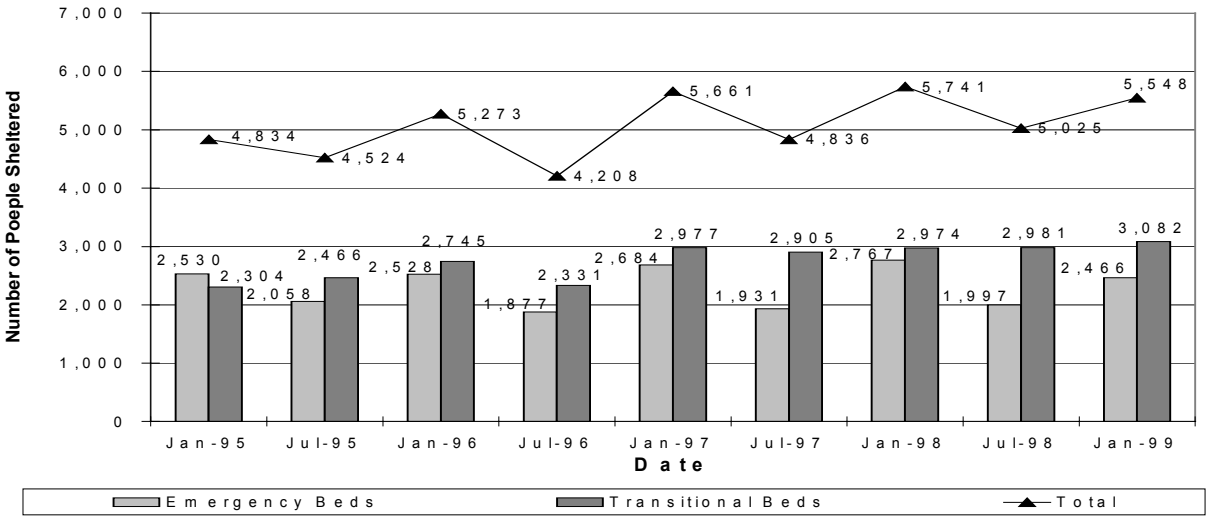
The chart below displays the number of beds the provider agencies have (regardless of whether or not the bed is currently filled) identified as either an emergency shelter bed or transitional housing bed. Motel voucher capacity is not included here because the number of units of shelter that can be purchased is subject to change based on varying rental costs and changing availability of funds to pay for vouchers. Capacity includes the last known bed counts for agencies that did not respond to a specific survey.

Statewide Bed Capacity: Nine Survey Comparison



The chart below displays the actual or estimated counts of people who were in shelter facilities or in motels or apartments for which rent was paid by a service provider on the night of the designated survey date. The counts are broken out into two columns by type of shelter: emergency (including motel vouchers) or transitional. The total number of beds occupied is displayed on the horizontal axis.

Homeless People Sheltered: Nine Survey Comparison

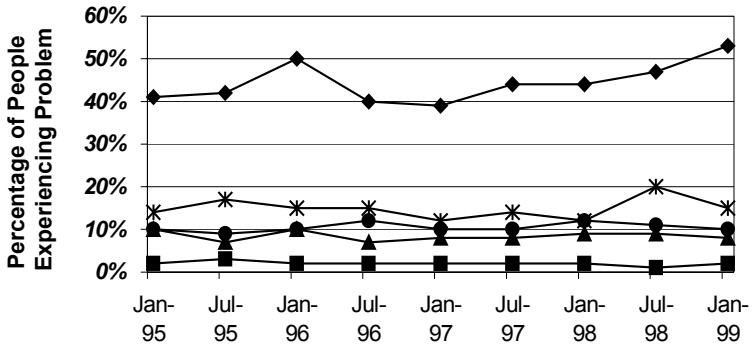


This chart includes estimates made by the staff of homeless service providers of selected types of problems experienced by the homeless people who received shelter. The types of problems include serious mental illness; serious mental illness AND abuse of alcohol or other drugs; OR abuse of alcohol or other drugs. Any one individual can be counted in ONLY ONE of these three categories but may appear in one of these AND one or both of the remaining problem categories: domestic violence; and AIDS or related diseases. When calculating the percent of people experiencing serious mental illness, alcohol/drug abuse, or serious mental illness and alcohol/drug abuse, the number of people is divided by the number of homeless adults sheltered (excludes children). When determining the number of people experiencing domestic violence and AIDS or related diseases, the number of people experiencing the problem is divided by all of the homeless people sheltered (includes children).

Problems Experienced by Homeless People: Nine Survey Comparison

In January 1999, 53 percent of the homeless population was experiencing a problem with substance abuse. When dually diagnosed individuals are added, the percentage rises to 63 percent.

The number of homeless substance abusers in Arizona in January 1995 was 1,318. In January 1999 the number had risen to 2,141. This is a 62 percent increase in the number of homeless substance abusers.



	Jan-95	Jul-95	Jan-96	Jul-96	Jul-97	Jan-98	Jul-98	Jan-99
Seriously Mentally Ill	10%	7%	10%	7%	8%	9%	9%	8%
Seriously Mentally Ill and Alcohol/Other Drugs	10%	9%	10%	12%	10%	12%	11%	10%
Alcohol/Other Drugs	41%	42%	50%	40%	44%	44%	47%	53%
Domestic Violence	14%	17%	15%	15%	14%	12%	20%	15%
AIDS/Related Diseases	2%	3%	2%	2%	2%	2%	1%	2%

Date

Overall, the percentage of reported substance abusers in the homeless population has risen 12 percent in the period between January 1995 and January 1999.

While the percentage of homeless people in shelter experiencing domestic violence appears to remain steady between 1995 and 1999, the numbers are sharply increasing. In January 1995, 682 homeless people were victims of domestic violence. In January 1999, 848 homeless people were victims of domestic violence. This is a 24 percent increase in the number of sheltered homeless people experiencing domestic violence in Arizona.

The same trend is occurring with homeless people with AIDS or related diseases. The percentage is consistently between one and three, but the numbers are rising. The number of people in shelter with AIDS or related diseases has risen 26 percent between January 1995 and January 1999.

B. Demographic Characteristics of Homeless People in Arizona

The following demographics are taken from reports provided by various agencies or groups. Each report and survey method is different. A brief description of each report and survey method can be found below.

ETHNICITY					
County/Agency	**American Indian**	**Black**	**Hispanic**	**Other**	**White**
Maricopa CAA's (1)	7%	10%	39%	< 1%	44%
Maricopa CASS (2)	4%	19%	28%	1%	48%
Pima	8%	13%	14%	6%	58%
Yuma	2%	8%	32%	<1%	58%

GENDER	
Female	**Male**
52%	48%
20%	80%
24%	76%
-	-

AGE						
County	**17 and under**	**18-23 **18-30**	***24-44 **31-59 ***24-29**	***45-54 **60-64 ***30-39**	***55-69 **65-74 ***40-49**	***70+ **75+ ***50+**
*Maricopa 1	45%	9%	*36%	*7%	*2%	*<1%
**Maricopa 2	8%	**23%	**66%	**2%	**<1%	**<1%
***Pima	1%	6%	***8%	***30%	***35%	***18%

LEVEL OF EDUCATION				
County	**No High School Degree**	**High School Degree**	**Some College or Trade**	**College Grad. or Beyond**
Maricopa 1	57%	29%	12%	2%
Pima	31%	33%	26%	9%

VETERAN STATUS	
County	**Veterans**
Maricopa 1	6%
Pima	39%

DISABILITY STATUS
Physical Disability
22%
32%

EMPLOYMENT STATUS	
Employed	**Looking for Work**
-	-
36%	61%

LENGTH OF TIME HOMELESS					
County	**Less Than a Week**	**7-30 Days**	**1-6 Months**	**6-12 Months**	**1 Year or Longer**
Pima	7%	14%	29%	11%	39%

TYPES OF ASSISTANCE RECEIVED IN LAST 30 DAYS					
County	**AHCCCS**	**Food Stamps**	**General Assistance**	**SSI/SSDI**	**TANF**
Maricopa 1	-	15%	<1%	7%	8%
Pima	11%	31%	5%	9%	4%

Maricopa County Community Action Agencies (1)-The population reported on consists of all homeless individuals (3,234 people in single and multi-person households), who applied for a service from one of the 13 Community Action Agencies operated by Maricopa County between July 1, 1998 and June 30, 1999. The data in the categories of age and gender is based on the number of individuals

served (3,234 people). The data in the other categories is based on the applicant of the household being served (1,292 households).

Maricopa County Central Arizona Shelter Services (CASS) (2)-The population being reported on consists of homeless singles who stayed at CASS' Men's and Women's shelters and homeless families who stayed at CASS' Vista Colina Family Shelter between July 1, 1998 and June 30, 1999. The total number of people reported on is 5,231. It should be noted that the men's shelter serves 326 men and the women's shelter serves 70 women. The family shelter has 30 apartments occupied mostly by female-headed households. This means that approximately three fourths of the population reported on are single homeless individuals, and approximately one fourth is families.

Pima County-A total of 2,158 homeless individuals were interviewed at 35 sites in the Tucson area in October 1997 and February 1998. The Stewart B. McKinney Homeless Assistance Act definition of homelessness (see Section I of this report) was used for this survey. (Snow, D. A., & Shockey, J. (1998). Report on Tucson's Homeless Population 1997-1998. Tucson: University of Arizona, Department of Sociology).

Yuma-Data represents demographics of 1,467 homeless individuals and families who stayed at Crossroads Mission in Yuma between July 1, 1998 and June 30, 1999.

IV. Efforts to Prevent or Alleviate Homelessness

A. Federal Agency Programs

Department of Health and Human Services (DHHS)

Department of Health and Human Services, (n.d/1999). *Homelessness Programs in HHS*. [WWW document]. URL http://aspe.os.dhhs.gov/progsys/homeless/Programs.htm

Basic Centers Programs

The purpose of the Basic Center Program is to support agencies that provide crisis intervention services to runaway and homeless youth outside the traditional juvenile justice and law enforcement systems. The overall goal of the Program is to reunite youth with their families whenever possible, or to arrange for other suitable placements. To achieve this purpose, the Family and Youth Services Bureau (FYSB) of HHS awards discretionary grants annually on a competitive basis. The Agency solicits applications through a Federal Register announcement. Applications are competitively reviewed by peer panels and successful applicants generally receive three-year grants.

Battered Women's Shelter

This program provides grants to states and Indian tribes to provide immediate shelter and related assistance for victims of family violence and their dependents. Federal funding for battered women's shelters is made through the Family Violence/Battered Women's Shelters program, which was $72.8 million in FY 97, a portion of this grant goes toward funding shelters. In FY 97, approximately $66 million went to fund battered women's shelters.

Education and Prevention Grants to Reduce Sexual Abuse of Runaway and Street Youth

This program provides street-based outreach and education, including treatment, counseling, and provision of information and referrals to runaway, homeless, and street youth who have been subjected to or are at risk of sexual abuse. These services are being coordinated with existing services for runaway and homeless youth, namely emergency shelter and transitional living efforts. The coordination of resources and programs will increase the capacity of service providers to provide outreach to street youth.

Health Care for the Homeless

The Health Care for the Homeless (HCH) Program seeks to improve access by homeless individuals to primary health care, mental health and substance abuse treatment. HCH awards grants to community-based organizations including community health centers, local health departments, and community coalitions located in both rural and urban areas. The total FY 97 appropriation for the HCH program was $69.4 million. The 123 Health Care for the Homeless grantees, located in 48 States, the District of Columbia and Puerto Rico, are serving more than 450,000 homeless persons annually through more than 500 delivery sites. Services include primary care, substance abuse treatment, case management and eligibility assistance. HCH Program is run through the Bureau of Primary Health Care in the HHS' Health Resources and Services Administration.

The Outreach and Primary Health Services for Homeless Children Program is a subset of HCH, which seeks to address the needs of the homeless families with children who make up approximately twenty-nine percent of the population served.

Projects for Assistance in Transition from Homelessness (PATH)

PATH Formula Grant Program funds community-based programs to combat homelessness in every American state and territories. PATH provides a variety of treatment formula grant awards to States for homeless people with mental illnesses and co-occurring substance abuse problems, including treatment, support services in residential settings, and coordination of services and housing.

Using formula grants, the PATH program provides funds to each State, the District of Columbia, Puerto Rico, and four U.S. Territories to support service delivery to individuals with serious mental illnesses, as well as individuals with serious mental illness and substance use disorders, who are homeless or at risk of becoming homeless. PATH funds may be used for:

- *Outreach*
- *Screening and diagnostic treatment services*
- *Habilitation and rehabilitation services*
- *Community mental health services*
- *Alcohol or drug treatment services (for mentally ill individuals with co-occurring substance use disorders)*
- *Staff training*
- *Case management services*
- *Supportive and supervisory services in residential settings*
- *Referrals for primary health services, job training, and education services*
- *A limited set of housing services*

During FY 1996, approximately 76,000 persons received outreach or other PATH-supported services. In FY 1997, 56 states and territories received $20 million in PATH formula grant funds. They also receive technical assistance in the administration and design of service programs funded under PATH, including workshops and on-site assistance.

Runaway and Homeless Youth

The Runaway and Homeless Youth Program provides grants to local public and private organizations to establish and operate local runaway and homeless youth centers to address the crisis needs of these youth and their families. Funds support the Basic Center Program which supports youth shelters that provide emergency shelter, food, clothing, outreach services and crisis intervention for runaway and homeless youth. The shelters also offer services to help reunite youth with their families. The Transitional Living Program for Homeless Youth assists older homeless youth in developing skills and resources to promote independence and prevent future dependency on social services. Housing and a range of services are provided for up to 18 months for youth age 16 - 21 who are unable to return to their homes.

A small portion of the program funding (approximately ten percent) supports a national toll-free hotline; training and technical assistance activities; various research and demonstration projects on topics including teenage prostitution and chronic runaways; and increasing utilization of the centers by minority youth.

Transitional Living Program for Homeless Youth

The purpose of the Transitional Living Programs (TLP) is to help homeless youth, ages 16 through 21, make a successful transition to self-sufficient living and avoid long-term dependency on social services. The Family and Youth Services Bureau (FYSB) funds local agencies that provide young people with comprehensive services in a supervised living arrangement for up to 18 months. To achieve this purpose, FYSB awards discretionary grants on a competitive basis. Successful applicants receive three-year grants. In fiscal year 1996, the $14.9 million appropriation allowed FYSB to fund over 75 TLP projects.

Department of Housing and Urban Development (HUD)

Department of Housing and Urban Development (HUD) (n.d/1999). *Hud's Homeless Assistance Web Page.* [WWW document]. URL http://www.hud.gov/cpd/homeless.html

Continuum of Care

A strategic objective of the U.S. Department of Housing and Urban Development (HUD) is to "help communities and states establish a full continuum of housing and services designed to assist homeless individuals." HUD helps communities develop a holistic system through a community-based process that provides a comprehensive response to the differing needs of homeless individuals and families. HUD works with communities to establish cost-effective "Continuum of Care" systems in which gaps in the housing and services needed to move homeless families and individuals into permanent housing are identified and filled.

Emergency Shelter Grants

Emergency Shelter Grants (ESG) awards grants for the rehabilitation or conversion of buildings into homeless shelters. It also funds certain related social services, operating expenses, homeless

prevention activities, and administrative costs. ESG supplements State, local, and private efforts to improve the quality and number of emergency homeless shelters. By funding emergency shelter and related social services, ESG provides a foundation for homeless people to begin moving to independent living.

Single Room Occupancy

The Single Room Occupancy (SRO) Program provides Section 8 rental assistance for moderate rehabilitation of buildings with SRO units-single-room dwellings, designed for the use of an individual, that often do not contain food preparation or sanitary facilities. A public housing authority makes Section 8 rental assistance payments to the landlords for the homeless people who rent the rehabilitated units. Due to their small size, SRO units are less expensive to rent than regular apartments, so they often serve as the only affordable housing option for many low-income individuals and homeless persons. Such units are in short supply, however, since they yield negligible profits for building owners. The SRO program keeps some of these units available by providing rental assistance to owners for the cost of some rehabilitation, ownership, and maintenance of SRO units. Rental assistance payments cover the difference between the tenant's rental payment (generally 30 percent of the tenant's adjusted income) and a unit's rent, which must not exceed the fair market rent for the area.

Shelter Plus Care

Shelter Plus Care (S+C) provides rental assistance that, when combined with social services, provides supportive housing for homeless people with disabilities and their families. Homeless people with disabilities often need more than shelter to live independently: they often need medical care or other social services. Shelter Plus Care provides them with rental assistance in connection with support services from other providers. The program allows for a variety of housing choices such as group homes or individual units, coupled with a range of supportive services (funded by other sources). Grantees must match the rental assistance with supportive services that are at least equal in value to the amount of HUD's rental assistance.

Supportive Housing Program

Supporting Housing Program (SHP) provides grants to develop supportive housing and services that will enable homeless people to live as independently as possible. SHP helps develop housing and related supportive services for people moving from homelessness to independent living. Program funds help homeless people live in a stable place, increase their skills or income, and gain more control over the decisions that affect their lives.

Department of Veterans Affairs (DVA)

Department of Veteran Affairs (n.d/1999). *Special VA Homeless Assistance Programs and Initiatives.* [WWW document]. URL http://www.va.gov/health/homeless/AssistProg.htm

Domiciliary Care for Homeless Veterans (DCHV)

VA's Domiciliary Care for Homeless Veterans (DCHV) Program sites provide biopsychosocial treatment and rehabilitation to homeless veterans. The treatment component takes place in almost 1,500 dedicated beds at 35 VA medical centers. The program provides residential treatment to approximately 3, 500 homeless veterans with health problems each year. The average length of stay in the program is 4 months.

Homeless Chronically Mentally Ill Program (HCMI)

VA's 61 Homeless Chronically Mentally Ill (HCMI) Veterans' program sites provide extensive outreach, physical and psychiatric health exams, treatment, referrals, and ongoing case management to homeless veterans with mental health problems (including substance abuse). As appropriate, the HCMI program places homeless veterans needing longer term treatment into one of its 150 contract community-based facilities. The program serves over 20,000 homeless veterans each year, with over 3,000 receiving residential treatment. The average length of stay is 73.5 days in community-based residential care, and the average cost per day is approximately $39.00.

VA Assistance to Stand Downs

VA programs and staff have actively participated in each of the over 50 Stand Downs for Homeless Veterans run by local coalitions in various cities each year. In wartime stand downs, front line troops are removed to a place of relative safety for rest and needed assistance before returning to combat. Similarly, peacetime stand downs give homeless veterans 1-3 days of safety and security where they can obtain food, shelter, clothing, and a range of the types of assistance, including VA provided health care, benefits certification, and linkages with other programs.

VA's Homeless providers Grant per Diem Program

The Grant/Per Diem Program assists nonprofit and local/state government agencies in establishing housing or service centers for homeless veterans. Grants are awarded for the construction, acquisition, or renovation of facilities, and for the purchase of vans for the transportation of homeless veterans. Partial operating funds may be provided for programs through per diem payments.

VBA-VHA Special Outreach and Benefits Assistance

VHA has provided specialized funding to support twelve Veterans Benefits Counselors as members of HCMI and Homeless Domiciliary Programs as authorized by Public Law 102-590. These specially funded staff provide dedicated outreach, benefits counseling, referral, and additional assistance to eligible veterans applying for VA benefits. This specially funded initiative complements VBA's ongoing efforts to target homeless veterans for special attention. To reach more homeless veterans, designated homeless veterans coordinators at VBA's 58 regional offices annually make over 4,700 visits to homeless facilities and over 9,000 contacts with non-VA agencies working with the homeless and provide over 24,000 homeless veterans with benefits counseling and referrals to other VA programs. These special outreach efforts are assumed as part of ongoing duties and responsibilities. VBA has also instituted new procedures to reduce the processing times for homeless veterans' benefits claims.

B. State Agency Programs

Arizona Department of Commerce (ADOC)

Arizona Department of Commerce (DOC) (n.d/1999). *Office of Housing and Infrastructure Development: Brief Program Descriptions* [WWW document]. URL http://www.commerce.state.az.us/housing/houspg.shtml

Arizona Housing Trust Fund

Established in 1988, the Arizona Housing Trust Fund (HTF) was created to provide a flexible funding resource for local governments and nonprofit housing organizations to help them provide affordable housing opportunities to low- and moderate-income families in Arizona. The HTF receives money from a 55 percent allocation (beginning in FY 98) of unclaimed property deposits and interest on unexpended funds.

Community Development Block Grant (CDBG)

The Department of Commerce, Office of Housing and Infrastructure Development (HID) administers the federal Community Development Block Grant (CDBG) Program for non-metropolitan counties in Arizona. Approximately $10 million is available every year to local governments for housing and community development needs. The purpose of the CDBG Program is to "develop viable communities by providing decent housing, a suitable living environment and expanding economic opportunities, principally for persons of low and moderate income."

Federal HOME Program (FHP)

HOME is a federal housing block grant program created by the National Affordable Housing Act of 1990. It provides funds to state and local governments to design housing projects with nonprofit and for-profit developers. The Office of Housing and Infrastructure Development (HID) makes available approximately $5 million each year to local governments and nonprofit organizations statewide. Other areas of Arizona also receive direct HOME funding from the federal government, the Maricopa and Pima County Consortia and the city of Phoenix (approximately $12 million). HOME gives states and local governments the flexibility to decide what kind of housing assistance, or mix of housing assistance, is most appropriate to meet their housing needs.

Federal Low Income Housing Tax Credits

The Low Income Housing Tax Credit Program provides low-cost rental housing assistance to many Arizonans. Approximately $6 million in federal income tax credits is available annually to developers willing to build or rehabilitate residential multi-family apartment projects and make them affordable. This program provides a dollar-for-dollar credit against federal income tax liability for owner/developers of qualifying residential rental projects for a period of 10 years. The credit is intended to produce a cash subsidy to aid in the production of affordable housing and, in return, the developer agrees to restrict rents for a period of time. The federal tax credits finance approximately 60 percent of overall construction costs. To date, more than $44 million in tax credits has been allocated assisting in the creation of 10,000 units of low-income housing. These projects have leveraged more than $500 million in Arizona's construction industry.

Special Needs Housing

The Special Needs Housing Office helps develop affordable housing opportunities for a variety of special-needs groups. The office administers HUD grants and provides planning, technical assistance and program advocacy services to organizations and agencies serving low-income special-needs groups. HID currently administers nine HUD grants providing supportive housing to over 1,000 homeless persons with serious mental illness throughout Arizona, with an annual expenditure for housing and services of more than $10 million. The program works to coordinate all resources, including federal, state and local, to increase emphasis and funding for special-needs housing. Special-needs groups identified include, but are not limited to, serious mental illness, chronic substance abuse, HIV/AIDS, homeless, victims of domestic violence, developmentally disabled, farm workers and frail elderly.

State Public Housing Authority

HID is a new state Public Housing Authority (PHA) formed by the Legislature in 1992. The state PHA was created to ensure that federal Section 8 rental assistance resources were made available to portions of Arizona not served by local PHAs. Many rural areas of the state are in desperate need of housing assistance but without local PHAs to provide it. This program allows the state to seek the funds needed to serve these areas. HID currently administers 39 Section 8 certificates and vouchers in Yavapai and Graham Counties. It is estimated that this $1.2 million program will help 120 low-income households with rental assistance over the next five years.

Arizona Department of Economic Security (DES)

Domestic Violence Shelter Fund (DVSF)

DES receives a percentage of all court filing fees collected by Arizona counties. These funds are used to provide emergency domestic violence shelter, advocacy and support services.

Domestic Violence Prevention (DVP)

DES receives approximately $1.3 million state appropriated funds. DES contracts these funds for such services as counseling, shelter, transportation and child care.

Emergency Community Services for the Homeless (EHP)

EHP was established and is funded through the Stewart B. McKinney Act. It is associated with the Community Services Block Grant. Funds are received from the Federal Department of Health and Human Services (HHS) and are passed through DES to the Community Action Agencies (CAAs). The CAA's planned locally for the use of the funds. Up to 25 percent of the funds could be used for prevention services (such as prevention of eviction or utility shutoff). Congress, effective in FY 1997, terminated this fund source. Only $18,836 was in the SFY 1997 budget.

Emergency Shelter Grant (ESG)

The ESG program was established under the Stewart B. McKinney Homeless Assistance Act. The Department of Housing and Urban Development (HUD) administers the program. The primary intent of ESG is to provide funds for renovation/rehabilitation and operating expenses for homeless shelters (funding of staff costs are not allowed). However, some prevention services (prevention of eviction or utility shutoff) and essential social services are allowed.

Homeless Trust Fund (HTF)
The legislation that established the fund made available $200,000 the first year (1991) and the amount of interest earned on the $800,000 trust fund base in subsequent years. Homeless services provided with these funds are based on the priorities set by the Homeless Trust Fund Oversight Committee. In FY 1999, the top priorities were emergency shelter/transitional housing, employment-related services, and the prevention of homelessness.

Social Services Block Grant (SSBG)
SSBG is also known as Title XX. This fund source is not homeless specific. However, part of the available funds, some of which are planned at a local level and some at a department (DES) level, have been planned specifically for service to domestic violence victims and some more generally for homeless people. crisis intervention (which includes shelter and counseling) is provided for domestic violence victims. Services funded for homeless people in general include crisis intervention, case management, and transportation. The Department of Health and Human Services (HHS) administers the SSBG funds.

State Appropriation
These funds are appropriated for homeless shelter as a line item in the DES budget. The funds are contracted out to pay for the costs of shelter facilities and services and to provide motel and hotel vouchers.

Temporary Assistance for Needy Families (TANF)
The TANF funds are available through Title IV-A of the Social Security Act which are administered by the Department of Health and Human Services (HHS). The state must submit amendments to the State Plan for Temporary Assistance for Needy Families in order to establish a TANF emergency services plan. Although the federal regulations do not specify that eligible clients be homeless, they do allow a State TANF plan, or a portion of the plan, to be limited to a type of problem such as homelessness. TANF requires a maintenance of effort match from the state. Therefore, Arizona has used a portion of the state appropriated funds for homeless people assigned to DES to match TANF through a plan which allows shelter (at a facility or by voucher), prevention, move-in assistance and case management service. The Department is currently reviewing options to expand the range of services available for homeless and near homeless families.

Note: In addition to the above listed fund sources, DES serves homeless persons with other fund sources/programs, which are not limited to homeless persons. These services include TANF Cash Assistance, General Assistance, Short Term Crisis Services, Food Stamps, Job Services and Job Training Partnership Act.

Homeless Coordination Office
The Arizona State Homeless Coordination office was created in 1991 by A.R.S. Section 41-1954 (A) which establishes "an office to address the issue of homelessness and to provide coordination and assistance to public and private non-profit organizations which prevent homelessness or aid homeless individuals and families throughout this state. These activities shall include:

1. Promoting and participating in planning for the prevention of homelessness and the development of services to homeless persons.

2. Identifying and developing strategies for resolving barriers in state agency service delivery systems that inhibit the provision and coordination of appropriate services to homeless persons and persons in danger of being homeless.

3. Assisting in the coordination of the activities of federal, state and local governments and the private sector which prevent homelessness or provide assistance to homeless people.

4. Assisting in obtaining and increasing funding from all appropriate sources to prevent homelessness or assist in alleviating homelessness.

5. Serving as a clearinghouse on information regarding funding and services available to assist homeless persons and persons in danger of being homeless.

6. Developing an annual state comprehensive homeless assistance plan to prevent and alleviate homelessness.

7. Submitting an annual report by January 1, 1992, and each year thereafter to the Governor, the President of the Senate and Speaker of the House of Representatives on the status of homelessness and efforts to prevent and alleviate homelessness."

Arizona Department of Education (ADOE)

U.S. Department of Education (DOE) (n.d/1999). *Guide to U.S. Department of Education Programs and Resources.* [WWW document]. URL http://web99.ed.gov/GTEP/Program2.nsf/02cbabc638062ed2852563b6006ffeae/ca9f99d511ac6c36852563bc005404e5?OpenDocument

Education for Homeless Children and Youth--Grants for State and Local Activities

Formula grants are made to the 50 states, the District of Columbia, and Puerto Rico based on each state's share of Title I funds. The Outlying Areas and the Bureau of Indian Affairs also receive funds. Among other things, the program supports an Office for Coordination of Education of Homeless Children and Youth in each state, which gathers comprehensive information about homeless children and youth and impediments to their regular attendance at school. These grants also help state education agencies to ensure that homeless children, including preschool and youth, have equal access to free appropriate public education. States must review and revise laws and practices that impede such equal access. States are required to have an approved plan for addressing problems associated with the enrollment, attendance, and success in school of homeless children. States must make subgrants to local education agencies to facilitate the enrollment, attendance, and success in school of homeless children and youth. This includes addressing problems caused by transportation issues, immunization and residency requirements, lack of birth certificates and school records, and guardianship issues.

With subgrant funds, local education agencies offer such activities as coordination and collaboration with other state agencies to provide comprehensive services to homeless children and youth and their families, and expedited evaluations of homeless children's needs to help facilitate enrollment, attendance, and success in school.

Arizona Department of Health Services (ADHS)

Projects for Assistance in Transition from Homelessness (PATH)

The PATH program is described under programs administered by the U.S. Department of Health and Human Services (DHHS). The Arizona Department of Health Services (ADHS) provides funding to agencies in Maricopa, Pima, and Coconino counties to operate the PATH program. This program is currently funded with $314,000 from DHHS and approximately $104,000 from ADHS.

Shelter Plus Care

The Shelter Plus Care program is described under programs administered by the U.S. Department of Housing and Urban Development (HUD). The Division of Behavioral Health Services of the Arizona Department of Health Services has the responsibility to administer services for persons with serious mental illness. State appropriated funds are used to provide services to approximately 1000 seriously mentally ill persons who receive housing subsidies provided by the Shelter Plus Care program. The Shelter Plus Care housing program is administered by the Arizona Department of Commerce.

Summary of Funding of Services to Homeless People through the State of Arizona Fiscal Years 1996-97, 1997-98 and 1998-99

	*Amounts are estimated and/or contracted funds	1996-97	1997-98	1998-99
1.	**DEPARTMENT OF ECONOMIC SECURITY (DES)**			
	Homeless Shelter (State)	$1,155,400	$1,155,400	$1,155,400
	Homeless Trust Fund	45,000	54,000	49,000
	Emergency Shelter Grant (HUD)	491,500	479,900	715,400
	Emergency Community Services for the Homeless (HHS)	18,800	-0-	-0-
	Social Services Block Grant (Domestic Violence) (HHS)	604,900	736,100	699,500
	Social Services Block Grant (HHS)	577,800	565,300	508,700
	Temporary Assistance to Needy Families (TANF) (HHS) *1/*	3,471,300	1,948,400	3,517,800
	Domestic Violence Shelter Fund	876,200	1,085,500	1,294,900
	SAFAH (HUD)	251,800	233,600	-0-
	SHP (HUD)	420,300	379,500	-0-
	Domestic Violence Prevention (State)	609,700	548,300	529,600
	SUBTOTAL DES	**$8,522,700**	**$7,186,000**	**$8,470,300**
2.	**DEPARTMENT OF HEALTH SERVICES (DHS)**			
	State Appropriation (Seriously Mentally Ill) *2/*	$5,450,000	$5,700,000	$5,573,300
	State Appropriation (Domestic Violence)	Not Available	Not Available	Not Available
	Projects for Assistance in Transition from Homelessness (HUD)	300,000	300,000	314,000
	Family Violence Prevention (HHS)	218,400	460,300	460,300
	SUBTOTAL DHS	**$5,968,400**	**$6,460,300**	**$6,347,600**
3.	**ARIZONA DEPARTMENT OF EDUCATION (ADE)**			
	Education for Homeless Youth	$322,200	$383,900	$444,700
	SUBTOTAL ADE	**$322,200**	**$383,900**	**$444,700**
4.	**ARIZONA DEPARTMENT OF COMMERCE (ADOC)**			
	HOME (HUD)	$609,700	$1,095,000	$400,000
	Arizona Housing Trust Fund	1,250,900	370,800	$1,827,900
	Permanent Housing (HUD) *3/*	5,350,000	5,600,000	5,468,700
	SUBTOTAL ADOC	**$7,210,600**	**$7,065,800**	**$7,696,600**
	STATE TOTAL	**$22,023,900**	**$21,096,000**	**$22,959,200**

1/ In 1996-97, under the predecessor program of TANF (Emergency Assistance to Families), certain activities were reported to have a homeless service intent. Under the TANF program for 1997-98 and 1998-99, those funds are under a Community Action Services intent and may be used to assist homeless or near-homeless persons, but are not classified as homeless assistance for budget purposes.

2/ The amounts are estimated for 12 month periods. The amounts are primarily DHS match funds for PATH and HUD grants for Permanent Housing.

3/ The amounts are based on HUD Permanent Housing and Shelter Plus Care grants. The amounts are estimated for 12-month periods.

C. Local Programs

Local governments and non-profit agencies in Arizona play a major role in addressing homelessness. County and city governments provide funding and staff to support homeless assistance programs in their jurisdictions. This includes administration of federal grants that address homelessness as well as other federal funds that may be used for those purposes, such as the Community Development Block Grant. Some local governments appropriate funds for homeless programs. The City of Phoenix has authorized a homeless coordinator. The City of Phoenix has served as the grantee on behalf of agencies applying for Stewart B. McKinney homeless funding and has also received direct grants to operate programs. The City of Tucson plays a significant role in the McKinney grant application process and provides support to the Tucson Planning Council for the Homeless. City and county governments that operate Community Action Programs play a major role in providing assistance to households in crisis such as eviction prevention assistance and move-in assistance for those who are already homeless. There are also a number of Community Action Programs that are operated by non-profit organizations that provide the same types of assistance as government sponsored Community Action Programs.

Local non-profit providers of services to homeless persons are the primary source of emergency shelter and transitional housing for all of the homeless sub-populations identified in this report. Virtually all of these beds are provided by local non-profit agencies. Of those agencies that are known, 78 provide emergency shelter and 88 provide transitional housing, with some providing both services. A review of the data available to the DES Homeless Coordination Office indicates that there are at least 200 agencies that assist homeless persons in the state, including state and local government agencies. Fifty of these agencies are faith-based organizations. It is likely that many more faith-based groups assist homeless people.

The table on the next page provides information on the number of emergency shelter and transitional housing beds known to the Homeless Coordination Office that are available for homeless persons in the state.

Emergency and Transitional Housing Beds For Homeless People in Arizona: 1998-1999

(Excluding winter overflow beds)

	COUNTY	FAMILIES	YOUTH	INDIVIDUALS	TOTAL
EMERGENCY SHELTER BEDS	Apache	0	0	0	0
	Cochise	58	2	32	92
	Coconino	20	0	37	57
	Gila	14	0	5	19
	Graham/Greenlee	16	0	0	16
	La Paz	16	0	0	16
	Maricopa	804	26	702	1,532
	Mohave	36	20	0	56
	Navajo	34	0	0	34
	Pima	207	17	274	498
	Pinal	16	0	0	16
	Santa Cruz	16	0	15	31
	Yavapai	50	13	21	84
	Yuma	42	2	62	106
SUBTOTAL		**1,329**	**80**	**1,148**	**2,557**
TRANSITIONAL HOUSING BEDS	Apache	0	0	0	0
	Cochise	5	0	0	5
	Coconino	14	0	14	28
	Gila	0	0	23	23
	Graham/Greenlee	0	0	0	0
	La Paz	10	0	0	10
	Maricopa	1,663	30	1,219	2,912
	Mohave	13	0	0	13
	Navajo	0	0	0	0
	Pima	515	13	474	1,002
	Pinal	4	0	0	4
	Santa Cruz	0	0	0	0
	Yavapai	32	6	124	162
	Yuma	14	0	63	77
SUBTOTAL		**2,270**	**49**	**1,917**	**4,236**
TOTAL		**3,599**	**129**	**3,065**	**6,793**

Statewide Advocacy Organizations

There are several statewide organizations in Arizona which have at least as part of their mission a concern for homeless people in general or a specific population of homeless people. These include:

Arizona Coalition Against Domestic Violence (ACADV)
This coalition was formed in 1980, "to develop a system of networking among domestic violence programs, professionals, and interested citizens throughout Arizona. The goal of ACADV is to increase awareness of domestic violence, and to reduce violence in our state." By definition, residents of domestic violence shelters are considered to be homeless. Although some victims do return to the abusing partner, many make the decision to not return to the abusive situation. Therefore, one of the primary needs of individuals and families in such shelters is transitional and permanent housing.

Arizona Coalition to End Homelessness
This coalition was formed in January 1991. Part of its mission statement states:
"On behalf of homeless people, the Coalition will advocate for more and better emergency, transitional and permanent housing; for an increase in the supply of affordable housing; for an expansion of health care; and for social service policies that enable people to become self-sufficient.

The Coalition will participate in the political, economic, and legal processes on behalf of and in cooperation with homeless and low-income people."

2000 Legislative Recommendations:

1. Utilize a portion of the State's unspent TANF funds to provide additional housing and homeless assistance.

   - Establish a rental housing assistance program to assist homeless TANF families or families at-risk of needing TANF assistance for whom lack of housing is a barrier to seeking employment or working regularly. $1,000,000 should be earmarked to provide first and last month deposits for a move into affordable rental housing.

   - Transfer a portion of the unspent TANF funds to the Social Services Block Grant (SSBG) program to compensate for losses incurred during the FY 1999-2000 Congressional budget deliberations. Currently $499,157 of SSBG funds support homeless shelters in this state. A 25 percent reduction in the SSBG program would result in a $125,000 reduction for these homeless programs.

   - Allocate $500,000 for an eviction and foreclosure prevention program for families within the first six months of leaving TANF, that would provide assistance with rental or utility arrears, and any other financial crisis the family may experience because of unanticipated costs from employment, i.e. car repairs, other transportation needs, etc.

   - Allocate an additional $3,000,000 to homeless shelters for support services.

2. Facilitate the expansion of the Department of Corrections pre-release program to better assist offenders in finding permanent or transitional housing.

- The Department of Corrections should explore new ways to collaborate with other state agencies, including the Department of Health, Economic Security, and Commerce, as well as provider agencies seeking to assist homeless ex-offenders.

- The Department of Corrections should expand its pre-release program to better prepare all ex-offenders for release to the community. The emphasis of this pre-release program should be to assist potentially homeless inmates to secure permanent or transitional housing rather than emergency shelter upon release. The Department of Corrections should seek funding for this expanded pre-release program, temporary housing, halfway housing and support services through the legislative budget process.

- The Department of Corrections should assist all inmates in obtaining appropriate photo identification immediately upon release to the community.

- The Department of Corrections should intensify efforts to assist inmates who wish to be released to a rural area to secure housing and support services.

- The Arizona State Legislature should support efforts by the Department of Corrections to expand its pre-release program for ex-offenders.

- The Arizona State Legislature should expand its support for the development of affordable housing and housing assistance programs for the state's most vulnerable groups, including ex-offenders.

3. Utilize a portion of the State's Tobacco Settlement Funds to provide physical and behavioral healthcare for homeless individuals and families.

    - Earmark $500,000 from Tobacco Settlement Funds for healthcare for homeless individuals and families (medical and dental treatment).

    - Earmark $500,000 from Tobacco Settlement Funds for mental health and substance abuse treatment for homeless persons.

Arizona Community Action Association (ACAA)

The Arizona Community Action Association (ACAA) was incorporated as a non-profit organization in 1967 in response to a need for a statewide forum to address issues relating to poverty. Through its membership, ACAA has the capability to bring together public officials, low-income persons, representatives of the private sector and human service providers to share common concerns and to develop strategies to address poverty problems that are statewide rather than local in nature. In this way, ACAA strives to promote economic self-sufficiency for low-income people through collaborations which: strengthen, represent and promote Arizona's Community Action Agencies; encourage and enhance interagency cooperation; represent low-income concerns; assure maximum feasible participation of low-income people; develop partnerships with the public and private sectors; and engage in research and education related to developing solutions to poverty. In March 1999, the ACAA published the People's Infoguide: Where To Go For Help.

Arizona Hunger Advisory Council

This Advisory Council has received national recognition for its strong public-private partnerships within the Arizona anti-hunger network. It was established by the Arizona Legislature in the Charity Food Bank Act of 1986, and strives to address the issue of hunger and to assist organizations that aid hungry individuals throughout the state. Throughout the years, Council members have been instrumental in formulating and drafting innovative legislation, maximizing state inter-departmental cooperation on anti-hunger initiatives, substantially increasing business and volunteer participation in anti-hunger programs, and accessing funds and products for innovative uses to feed the hungry. This year, the Council produced its second report in a decade on the Status of Hunger in Arizona. The report examines the economic plight of low-income Arizonans who suffer the symptoms of hunger, and details the food programs targeted to assist those individuals and compares progress made, or new problems that developed since the first report in 1989. Additionally, it describes the barriers and challenges faced by clients and food service providers; charts the progress being made to alleviate hunger; and provides overall recommendations to address the many issues raised in the report.

Association of Arizona Food Banks (AAFB)

The Association of Arizona Food Banks was formed in 1984. A recognized 501(c)3 non-profit organization, it supports a cooperative network of member food banks, food pantries and other organizations that work, cost-effectively and efficiently to collect, store, transport and distribute food to hungry people throughout the state. The Association sees its mission as strengthening communities to build an Arizona where all people are well nourished. Toward that end, this statewide organization plays a key leadership role in Arizona by advocating for nutrition programs, as well as assisting in the coordination and implementation of those programs. It advocates for rural food banks, food stamp outreach, WIC, school lunch and breakfast, and summer food programs for at-risk children, to mention a few. The Association's statewide Gleaning Project is an innovative program designed to provide fresh fruits and vegetables to hungry people. The produce is gathered ("gleaned") after the regular harvest or collected from produce packing businesses throughout the agricultural centers of the state. Additional services provided by the Association are information and referral to food donors and needy people, and outreach efforts for food and nutrition programs.

Children's Action Alliance (CAA)

Children's Action Alliance (CAA), founded in 1988, is a nonprofit/nonpartisan research, policy, and advocacy organization dedicated to improving the lives and life chances of Arizona's most vulnerable children and families. CAA works to make the needs of children the subject of intense thought, debate, and action through research, publications, media campaigns, public education, and advocacy.

Community Development Coalition of Arizona (CDCA)

The Community Development Coalition of Arizona (CDCA) represents Arizona nonprofit organizations who provide affordable housing, shelter, community development, and continuum of care services. It's mission is to advocate for community development through adequate, safe, decent, fair and affordable housing, and a continuum of support services, through (1) leadership, (2) education and public policy advocacy, (3) capacity building and resource and professional development, and (4) cooperative and collaborative networking and support services. Membership is open to all who support the CDCA mission, including for-profit corporations and individuals.

CDCA:
1. maintains a policy agenda that lists priorities for action;
2. publishes a semi-quarterly newsletter;
3. keeps a master calendar of events and meetings of interest to our members;
4. holds quarterly networking events;
5. sends email and fax alerts regarding training and funding opportunities and issues of importance to members;
6. publishes a Resource Directory providing information about members' programs and areas of specialized expertise and experience; and
7. maintains a web site.

In 2000, CDCA intends to continue recognizing and promoting excellence in achievement and professionalism that positively impacts community development, affordable housing, and homelessness.

Governor's Homeless Trust Fund Oversight Committee

This committee is authorized by A.R.S. 41-2021 (A). The primary task of the committee is to "establish guidelines for the expenditure of fund monies to provide homeless shelter services". The Oversight Committee has developed a mission statement:

"It is the mission of the Homeless Trust Fund Oversight Committee to provide a focus for statewide activities to eliminate homelessness. These activities include but are not limited to:

1. Establishing guidelines to be used by the Department of Economic Security for the most effective and appropriate use of the Arizona Homeless Trust Fund, with particular emphasis on the needs of homeless families with children;
2. Assessing the needs of homeless persons in Arizona;
3. Identifying the resources being utilized to address the needs of homeless persons; and
4. Overseeing the development and implementation of a statewide plan to break the cycle of homelessness."

FY 2000 Guidelines for Use of the Homeless Trust Fund:

- Priority is to be given to families with children, as required by enabling legislation.
- At least three (3) awards should be made, with consideration for maximum statewide benefit and the needs of rural areas of the State.
- Providers shall be given maximum flexibility regarding the required 25 percent match.
- Programs which seek to empower the families/individuals being served shall be given additional consideration.
- Services which may be provided have been identified from the highest to the lowest priority:
- Emergency Shelter/Transitional Housing
- Employment Related Services
- Prevention of Homelessness
- Day Support Services
- Chemical Dependency Treatment
- Removal of Barriers to Services

Agencies which propose an innovative approach to service delivery or show collaborative commitments from other agencies to provide other support services shall be given additional consideration.

In 1999 the Homeless Trust Fund Oversight Committee issued revised policy statements regarding the following issue areas:

FY 2000 Policy Statements:

1. Treatment and Housing for Substance Abusers
2. Transitional Housing for Families
3. Employment Opportunities for Homeless Individuals
4. Removal of Barriers to Services for Homeless Persons
5. Day Resource Centers
6. Emergency Shelter/Support

The Arizona Coalition for Human Services (ACHS)

The Arizona Coalition for Human Services came into existence in 1984 for the purpose of increasing the Legislature's awareness of the growing health, education, and welfare needs of low-income populations that were not being addressed by our lawmakers. Since that time, ACHS Task Forces have researched the problems and inadequacies of human service delivery and put forth recommendations for the Legislature's consideration to assist in the task of developing an economical, efficient system of human services in Arizona. Each year the Coalition focuses its efforts on priority concerns that have a major impact on human services across all issue areas. For 1999, the Coalition has chosen to focus on: (1) tax policy/budget allocations; (2) expanded health care coverage; (3) full funding of a behavioral health system for all children and adults with a mental illness or substance abuse problem; (4) ensuring basic necessities for families;(5) allowing working parents to seek and maintain employment and protect their children; (6) provision for current and future food security needs; (7) restoration of benefits for hungry Arizonans; and (9) supporting special needs housing and home ownership programs.

Local Advocacy Organizations

There are many local groups, agencies and organizations in Arizona which have been advocating for and assisting in developing programs to assist homeless people. The following organizations are listed and described to provide an example of the types of activities local groups have successfully carried out:

Interfaith Coalition for the Homeless

The Interfaith Coalition for the Homeless (ICH) is composed of a consortium of interfaith congregations and organizations in the Tucson area whose purpose is to address the problems of homelessness within the Tucson community and to develop, coordinate and evaluate programs that permit congregations to serve homeless individuals and families.

During the 1997-1998 three-month winter season, over 6,500 bednights were provided to homeless families and individuals, while over $165,000 of program expenses were donated by congregation volunteers.

For these reasons, ICH is uniquely suited to serve as the lead agency for a brand new program to provide school-based interpersonal, material and health care support to many of the nearly 300 homeless and at-risk students who struggle to complete their high school education with minimal resources.

The goals of the Community, Congregation and Neighborhood (CCN) Homeless High School Mentoring project are to foster personal and academic responsibility within this group of "at risk" students by: a) supplying unmet basic needs and: b) establishing nurturing interpersonal relationships between these students and selected and trained congregational and community volunteers that are designed to foster successful academic and personal outcomes.

Homeless Veterans Coalition

The Homeless Veteran's Coalition is an ad hoc group committed to advocacy and improving the service delivery for homeless veterans in Maricopa County. The Coalition has been meeting on a bi-monthly basis since February, 1999 and is composed of representatives from Salvation Army, City of Phoenix, non-profit housing groups, the VA hospital, veteran's groups, DES and HUD. The Coalition has established goals to help create additional transitional and permanent housing, establish a drop-in center, and improve advocacy efforts for homeless veterans.

Phoenix Consortium to End Homelessness

The Phoenix Consortium to End Homelessness was founded in 1983 in recognition of the need to plan and advocate for a continuum of services that would address the needs of homeless people. Its bi-monthly meetings are attended by service providers in the greater Phoenix area, funding agencies, public sector representatives, and homeless and formerly homeless individuals. The meetings serve as a forum for the identification and resolution of homeless needs. They also create an opportunity for networking among providers, resulting in better coordination of services.

The Phoenix Health Care Coalition for the Homeless

The Phoenix Health Care Coalition for the Homeless mission is “To improve the physical and mental health of homeless men, women, and children of our Valley”. A major responsibility of the Coalition is to recommend how Comic Relief funds allocated to the City of Phoenix should be used. Its adopted Values Statements are:

- A healthy life, more than absence of disease, requires stable living, the ability to satisfy physical and emotional needs, and participation in a healthy and supportive community.

- Health care should be provided to homeless people as part of a broad continuum of care that includes food, clothing, shelter, and the individualized services needed for survival and movement toward self-reliance.

- Self-reliance in homeless people is strengthened when they are allowed to make treatment and service choices for themselves.

- Health services are incomplete if they do not include appropriate efforts to reintegrate people into their families and their community.

Tucson Planning Council for the Homeless (TPCH)

Tucson Planning Council for the Homeless is a broad-based coalition of organizations and individuals committed to reducing homelessness and improving the delivery of assistance to those who are homeless in the Tucson metropolitan area. Council membership includes representation of human service providers, religious groups, the business community, homeless advocates, local government and the community-at-large. The specific objectives are to:

1. Develop priorities for improving the homeless services network;
2. Advocate for actions necessary to achieve these goals;
3. Advise local planners and decision-makers regarding most effective uses of available resources;
4. Monitor progress toward developing a more coordinated and effective service delivery system;
5. Explore new strategies for better meeting local needs;
6. Identify significant trends and initiate response to emergent unmet needs; and
7. Create a forum for communication and information sharing among those involved in addressing the problem of homelessness in Tucson.

During 1999:

- TPCH's Winter Shelter Program provided 17,289 shelter bednights to homeless people during winter 1998-1999. Of these 4,971 bednights were coordinated through the voluntary participation of local religious congregations in collaboration with Tucson's Interfaith Coalition for the Homeless.

- TCPH has developed a plan of action, including an emergency and non-emergency response system in the event of a natural disaster or closure of homeless and housing programs that may leave a significant number of person's homeless with minimal notice. This response plan will be implemented only as needed, but allows the community and local government to know that the homeless providers are prepared.

- TPCH representatives worked with the Mayor's Task Force on Homelessness to present a proposal for six homeless multi-service centers, one in each city ward. The Toole Avenue feeding center (located in downtown Tucson) continues to operate a program of expanded services and referrals as a part of this proposal.

- At the request of the mayor, TCPH member agencies specializing in youth services implemented a pilot project to deal with the influx of homeless youth that descends on the city's arts/crafts district every winter. Street outreach workers attempted to refer youth to services, while interfacing with local merchants and residents to address their needs. Since the inception of this project, the Merchant's Association has indicated that there is improvements specific to homeless youth occupying sidewalk and alley space.

- TPCH maintained a presence with local human service funding processes, with particular emphasis on the allocation of FEMA, HOME, CDBG and ESG funds. Council members also maintained active involvement with the statewide Arizona Coalition to End Homelessness,

encouraging full council participation where necessary. Many members also work with the National Alliance to End Homelessness as well as the National Coalition for the Homeless.

D. Current Efforts

Homeless Youth Intervention Pilot Program

The Arizona State Legislature allocated $400,000 to the Department of Economic Security in each of fiscal years 1999-2000 and 200-2001 to establish a homeless youth intervention program by January 1, 2000. The program shall provide services to homeless youth who are referred based on a screening and assessment by the Department and are not currently served by the state child protective services or juvenile justice systems. The program must be operated in two locations in the state through collaborative partnerships between community social agencies, family support programs and other community organizations, which may include faith-based organizations. The focus of the program shall be to provide twenty-four hour crisis services, family reunification, job training and employment, assistance in obtaining shelter, transitional and independent living programs, a character education curriculum, and additional services deemed necessary by the Department to meet the needs for youth to achieve self-sufficiency.

The DES Homeless Coordination Office must include information about homeless youth in its annual report *Current Status of Homelessness in Arizona and Efforts to Prevent or Alleviate Homelessness*, including estimates of the number of homeless youth, demographics of this population, available programs and services for homeless youth, estimates of the number of youth currently being served by existing programs, and an estimate of the number of youth who sought assistance at a shelter program but could not be served. The Office is currently gathering information for inclusion in its annual report for 2000.

Joint Legislative Committee on Homelessness

The Joint Legislative Committee on Homelessness was established by SB1232 during the 1999 session of the Arizona Legislature. The Committee consists of four appointees from the Senate and four from the House of Representatives, and seven public members, including at least five representing provider agencies. The State Homeless Coordinator from the Department of Economic Security serves as an ex-officio advisor.

The Committee began meeting during the last quarter of 1999. Three study committees will make recommendations to the Joint Legislative Committee regarding three priority issues: Homelessness Prevention, Substance Abuse and Mental Health, and Support Services.

The Committee plans to issue a preliminary report in December 1999.

National Welfare Monitoring and Advocacy Partnership (NWMAP)

The Arizona Coalition to End Homelessness is coordinating the participation of Arizona social service agencies in a national survey on the impacts of welfare reform. A group called the National Welfare Monitoring and Advocacy Partnership developed the survey. The National Welfare Monitoring and Advocacy Partnership is comprised of organizations from across the country concerned about the impacts of welfare reform on their client populations and low-income people in general. The survey itself is being coordinated on the national level by the Children's Defense Fund and the National Coalition for the Homeless. Arizona has generated among the highest numbers of

surveys in the country thus far, with over 25 organizations in the state currently participating in the survey. The Arizona Coalition to End Homelessness expects to have the first comprehensive report on the Arizona survey data by the end of January 2000.

V. Resources

A. Ways To Help Homeless People

National Coalition for the Homeless (NCH) (February, 1999). *What You can Do.* [WWW document]. URL http://nch.ari.net/help.html

While the causes of homelessness are complex, there is much an individual can do to help. No matter what your skills, interests, or resources, there are ways you can make a difference for some of the men, women, and children who are homeless.

Volunteer work, advocacy efforts, and contributions of money, clothes, food, and services are all important and needed. Listed below are many suggestions.

Volunteer Activities

Working directly with homeless people is one of the best ways to learn about homelessness.

There is a lot of "behind the scenes" work (filing, sorting clothes, cutting vegetables, etc.) to be done at shelters and other service agencies. Think about what you do best and the kind of setting in which you work well: with individuals or groups, with men, women, or children. Then call a few places, ask what help they need, and arrange for a visit. You can find a partial listing of service providers on NCH's Online Directory of Local Homeless Service Organizations, or through NCH's Online Directory of Homeless & Housing Advocacy Coalitions.

Be patient - most programs are underfunded and understaffed. Staff are often overwhelmed with trying to meet people's basic needs or coping with emergencies. Let them know how you can help, when, and for how long. Don't commit to more than one visit or task until you're sure this is the place for you. Possible tasks include:

- *Work at a shelter: perhaps an evening or overnight shift. Help with clerical work: answer phones, type, file, sort mail. Serve food, wash dishes, sort or distribute clothes.*
- *Help build or fix up houses or shelters: check with your local public housing authority or Habitat for Humanity (their national number is 1-800-422-4828).*
- *Offer your professional skills and services directly or to assist in job training: many services and skills are needed, including secretarial, catering, plumbing, accounting, management, carpentry, tutoring, public relations, fundraising, legal, medical, dentistry, writing, child care, counseling, etc.*
- *Share your hobbies: teach a group, or work one-to-one with a homeless person.*
- *Help children: work with program directors who are coordinating field trips, picnics or art workshops for homeless children.*
- *Involve others: convince your classmates, co-workers, church members, or civic club to join, or support, your efforts.*

Contributions

While the concern and support demonstrated by volunteer work are essential, material help is a necessity too. The end to homelessness is a long road; in the meantime, homeless people and those running programs need help every day. Needed items include:

- *Clothing: The lack of clean, well-fitting clothes and shoes causes great hardship beyond exposure to the elements; it hurts one's self-image and one's chance to get ahead. No matter how many clothes homeless people used to have, they must travel light, with few opportunities to safely store, or adequately clean, what they can't carry. On job interviews, a poorly dressed person has little chance for success. Give your unused clothes to those who need them. Before you give your own clothes or start a clothing drive, talk to your local shelter: find out what items they really need. Most have limited storage space, and can't use winter clothes in summer or vice versa. Some serve only a certain group of people. Please clean the clothes before you donate them.*
- *Contribute in-kind services and materials: copying, printing, food, transportation, marketing assistance, computer equipment and assistance, electrical work, building materials, plumbing, etc.*
- *Donate household goods or other items: kitchen utensils, furniture, books, etc. Toys, games, stuffed animals, dolls, and diapers are also in high demand.*
- *Support a homeless person or family: as they move out of a shelter or transitional housing program, assist by contributing household goods, babysitting, moral support.*
- *Raise funds for a program: ask your group to abstain from one meal and donate the proceeds to a shelter or soup kitchen. Organize a bike or walk-a-thon, or a yard sale and donate the proceeds. Sponsor a benefit concert featuring local musicians (and include homeless musicians on the program).*
- *Give directly: carry fast-food certificates, change, extra sandwiches, or fruit to give to homeless people.*
- *Organize "survival kits" to give out to homeless people, with items like cups, pot, pan, soap, shampoo, toothpaste, toothbrushes, cosmetics. (Try coordinating this through a group that gives out meals from a van, for example). During cold weather organize drives for blankets, coats, hats, scarves, mittens and socks.*
- *Help homeless people contact loved ones: give them the opportunity to make free, long distance calls on special days.*
- *Encourage your company to hire homeless people: most homeless adults desperately want to work, but need an employer to give them a chance.*
- *Raise money for security deposits, to help families meet the first month's rent.*

Advocacy

Advocacy is critical to ending homelessness. Advocacy means working with homeless people to bring about positive changes in policies and programs on the local, state, and federal levels. It means working with various sectors of the community, e.g. city/county officials, Members of Congress, direct service providers, and members of the private sector, to develop workable strategies. Here are some ways you might help:

- *Respond to NCH's Legislative Alerts. These alerts give the most up-to-date information about what is happening in Congress affecting homelessness, and what you can do about it.*
- *Register homeless people to vote (see NCH's Voting Rights Project for more information).*

- *Volunteer at your local, sate, or national housing or homeless advocacy coalition. See NCH's Directory of Homeless & Housing Advocacy Coalitions for the name of the coalition nearest you. If you can't volunteer, send a donation.*
- *Attend neighborhood and public meetings and speak up in favor of low-income housing, group homes, shelters, and homelessness prevention programs.*
- *Organize site visits to homeless programs with political leaders and the media to highlight ways that your community is successfully addressing the many problems associated with homelessness.*
- *Call or write the media to inform them of your concern for homeless people in your area.*
- *Encourage homeless people, agency volunteers, and staff to write government officials, asking them to give the issue of homelessness top priority and to find humane solutions to the problem. Use opportunities like special holiday meals to do this; provide paper, pens, stamped envelopes, and sample messages at every meeting and event.*
- *Have a "Call In Day". Try getting a few people with mobile phones and go to shelters and meal programs to get homeless people, volunteers and staff to call the Governor (Mayor, Council member...) to stop future cuts in essential services. Or create a "reverse panhandling" activity: get homeless people and other volunteers to hand out quarters and ask people to call their legislators.*
- *Write letters to or call public officials at the city, county, state and federal levels asking what they are doing about homelessness. Mention relevant legislation. When legislators receive more than a few visits or letters about any subject, they sit up and take note. Personal visits are the most potent; letters and phone calls are next. Tell them your feelings and experiences. Addresses for public officials are available at the local library. For more information about communicating with Congress, see NCH's Advocacy Guide.*

Letters to Members of Congress may be addressed as follows:

To a Senator:
The Honorable (Firstname Lastname)
United States Senate
Washington, DC 20510

To a Representative:
The Honorable (Firstname Lastname)
U.S. House of Representatives
Washington, DC 20515
To call anyone in Congress: *Capitol Switchboard 202.224.3121*

Educate Yourself, Your Children, and Your Communities:
NCH maintains updated facts sheets on many aspects of homelessness, including causes, numbers, and special issues. Please read them to familiarize yourself with the latest information, and share them with your community: your place of worship, school, colleagues, friends, and neighbors.

Listed below are the names of some of the many books about homelessness. More information about these books can be found in our online library. See our list of videos for additional educational materials.
Homelessness in America, Jim Baumhol, 1996, Oryx Press. Available through NCH at 202.737.6444.
The Visible Poor: Homelessness in the United States, Joel Blau, 1992, Oxford University Press.

Rachel and Her Children: Homeless Families in America, Jonathan Kozol, 1988, Random House.
Tell Them Who I Am, Elliott Liebow, 1993, The Free Press-a division of Macmillan, Inc.
A Far Cry From Home: Life in a Shelter for Homeless Women, Lisa Ferrell, Noble Press, 1991.
American Homelessness, 2nd Edition, Mary Ellen Hombs, 1994, ABC-CLIO, Inc., 800/422-2546.
No Place To Be: Voices of Homeless Children, Judith Berck, foreward by Robert Coles, 1992,Houghton Mifflin.

For Children:
Please review these first to make sure they're appropriate for your child.
Cave under the City, Harry Mazer, 1986, HarperCollins.
Changing Places: A Kid's View of Shelter Living, Margie Chalofsky, et al., 1992, Gryphon House.
December Stillness, Mary Downing Hahn, 1988, Avon Books.
Fly Away Home, Eve Bunting, 1991, Houghton Mifflin Company.
The Homeless Hibernating Bear, by Kids Livin' Life, 1993, Gold Leaf Press, 800/748-4900.
I Want to Go Home, Elena Morrice and Lesley Koplow, 1988, The Center for PreventivePsychiatry, White Plains Clinic, 19 Greenridge Ave., White Plains, NY 10605.
Mandy's House: The Story of a Homeless Family Who Finds a New Place to Live, Ruth Spangler,1990, Society of St. Vincent de Paul, 1015-C S. Preston St., Louisville, KY 40203.
Mr. Bow Tie, Karen Barbour, 1991, Harcourt Brace Jovanovich.
Uncle Willie and the Soup Kitchen, Dyanne Disalvo-Ryan, 1990, Morrow and Company Inc.
We Are All in the Dumps with Jack and Guy, Maurice Sendak, 1993, HarperCollins.

What About Panhandling?

Many people write NCH to ask for advice about what to do when they encounter a homeless person asking for money.

The decision about whether or not to give money is an individual, personal decision. However, many people on the street -- those who are asking for money and those who are not -- are often passed by countless times as though they did not exist. Acknowledging a person's existence by looking at them is one of the most important ways to reaffirm his or her humanity at a time when homelessness seems to have stripped it away. Thus, whether or not you choose to give money, please don't look away as if the person doesn't exist.

Panhandling: A Little Understanding*, an article reprinted from San Francisco's Street Sheet, provides some insight into panhandling and homelessness.*

B. Sources of Assistance for Homeless People

- The DES Homeless Coordination Office publishes an annual list of all known homeless service providers in Arizona. This publication includes contact information as well as the number and array of services available at each agency. (This publication was formerly an appendix to this report).

- Community Information & Referral, Inc. in Phoenix and Information and Referral Services, Inc. in Tucson publish several directories, which contain a comprehensive listing of social service organizations in Arizona. The Directories provide contact information, the type of services available, and eligibility requirements.

- The Arizona Community Action Association publishes the People's Infoguide: Where To Go For Help periodically. It contains information on a variety of no-cost/low-cost programs and services available to low-income individuals or families. It is intended to assist individuals in obtaining resources needed to prevent a person or family from falling deeper into a crisis situation.